

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form P-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) ROBERT WALTER ANTON						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 5 26 1968			2b. HOUR ? M ?			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH Oct 27 1931		6. AGE (In years last birthday) 36 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		
7a. BIRTHPLACE (State or foreign country) Cecil County, Md.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL Md.				
10. CITY OR TOWN OF DEATH Elk Neck				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Elk Neck				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salvage			12b. KIND OF BUSINESS OR INDUSTRY Auto.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN Elk Neck		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER none		
14. FATHER'S NAME First Walter Middle Anton Last Anton				15. MOTHER'S MAIDEN NAME First Eleanor Middle Sapp Last Anton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. 219-28-8941		17. INFORMANT ADDRESS Barbara M. Anton, 402 S. 7th St., Reading, Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARBON MONOXIDE POISONING 9521 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 9703												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. Bishops Corner		City or Town Del.		County Del. State Del.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Henry V. Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 5/30/68				
EXAMINER'S NAME (Type) HENRY V. DAVIS MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS Chesapeake City, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION (City or Town) (County) (State) Bishops Corner Del.				
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				ADDRESS Donnell Ave Elkton, Md.				25a. RECD BY REGISTRAR JUN 3 1968		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06932

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1. DECEASED-NAME (Type or print) First Middle Last Martha M Bailey			2a. DATE OF DEATH 5 Month 30 Day 68 Year		2b. HOUR 11 A M
3. SEX F	4. RACE C	5. DATE OF BIRTH Aug. 29, 1897		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil Md.		
10. CITY OR TOWN OF DEATH Port Deposit Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2247 Main St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic	12b. KIND OF BUSINESS OR INDUSTRY Private Fam.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey	13b. COUNTY Atlantic City	13c. CITY OR TOWN Atlantic City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 5217 New York Ave.	
14. FATHER'S NAME First Middle Last William H. Smith	15. MOTHER'S MAIDEN NAME First Middle Last Charlotte Ann Wilson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. ---	17. INFORMANT Address Mrs. Hannah Taylor, Port Deposit, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) ---					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-25, 1968 , to 5-30, 1968 , that (I) (we) last saw the deceased alive on 5-30, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Neil R Taylor DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 5-31-68
22d. PHYSICIAN'S NAME (Type) Neil R Taylor, MD		22e. ADDRESS Rising Sun, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 3, 1968	23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery	23d. LOCATION (City or Town) (County) (State) Darlington, Maryland		
24. FUNERAL DIRECTOR Otha J. Bullock, Harrode Trace, Md.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH </div>											
1. DECEASED NAME (Type or print) First Middle Last Louisa Way Blackburn						2a. DATE OF DEATH Month Day Year May 27 68			2b. HOUR 9:30 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 16, 1883			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Co. Md.					
10. CITY OR TOWN OF DEATH Colora Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife Ret.			12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Colora		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. # 1			
14. FATHER'S NAME First Middle Last Francis L. Way				15. MOTHER'S MAIDEN NAME First Middle Last Mary Eva Killough							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT J. Frankie Way				Address Colora Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> , 19 <u>48</u> , to <u>5-27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>G.H. Richards Jr.</i>								DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/27/68	
22d. PHYSICIAN'S NAME (Type) G.H. Richards Jr. MD.				22e. ADDRESS Port Deposit Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-30-1968		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.		23d. LOCATION (City or Town) (County) (State) Colora Cecil Md.					
24. FUNERAL DIRECTOR <i>Thomas E. Miller</i>				ADDRESS Rising Sun Md.		25a. REC'D BY REGISTRAR JUN 3 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) SALLIE BRISCOE			2a. DATE OF DEATH May Month 22 Day 1968			2b. HOUR 7:30 P.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH April 5, 1893		6. AGE (In years last birthday) 75 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Alice Brooks		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 219-36-0172		17. INFORMANT Harry Briscoe		Address R.D. 2 North East, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11, 1967 , to 5-22, 1968 , that (I) (we) last saw the deceased alive on 5-22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jay S. Barnhart Jr. M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-24-68	
22d. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.				22e. ADDRESS 4 Mauldin Ave. North East, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-27-68		23c. NAME OF CEMETERY OR CREMATORY St. Mark's		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.	
24. FUNERAL DIRECTOR Grant Funeral Home				25a. REC'D BY REGISTRAR DATE MAY 27 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-64
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Charles E. Bryson					May 9, 1968			
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male	White	July 17, 1903			64 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Maryland	U.S.A.			Cecil		Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Elkton	Union Hospital		Mechanic		Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER				
Maryland	Cecil	Elkton		405 Bridge St.				
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last						
Charles J. Bryson		Reba H. Hutton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		220-12-6990		Donald J. Bryson, Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>4-18</u> , 19 <u>68</u> , to <u>5-9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5-9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Tillman D. Johnson M.D.</u> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>5-9-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Tillman D. Johnson M.D.</u>				22e. ADDRESS <u>1235 Singard Ave, Elkton, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/13/68	North East Meth.		North East, Md.			
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00935

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c LENGTH OF STAY IN lb <u>Life</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital of Cecil County</u>				d STREET ADDRESS <u>136 Maffit Street, Elkton, Md.</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Willard W Bryson</u>				4 DATE OF DEATH Month Day Year <u>May 15, 1968</u>			
5. SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>9-17-05</u>	
9 AGE (in years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parts Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Elkton Cecil Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Walter J. Bryson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hoover</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16 SOCIAL SECURITY NO <u>213-05-6161</u>		17. INFORMANT <u>Alice E. Bryson (Wife)</u> Same Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 16d.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Liver and Lungs</u> DUE TO (c) <u>Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-Days</u> <u>1-Month</u> <u>5-Days</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1972</u>				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/23/1968</u> to <u>5/15/1968</u> , that (I) (we) last saw the deceased alive on <u>5/11/1968</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>James L. Johnson</u> 22c. PHYSICIAN'S NAME (Type) <u>James L. Johnson M.D.</u>				22b. DATE SIGNED <u>5-16-68</u>		22d. ADDRESS <u>245 E. High St., Elkton Cecil Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-18-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NORTH EAST METH.</u>		23d. LOCATION (City or Town) (County) (State) <u>NORTH EAST CECIL MD.</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pippin</u> <u>PIPPIN FUNERAL HOME ELKTON MD.</u>				25a. REC'D BY REGISTRAR <u>MAY 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

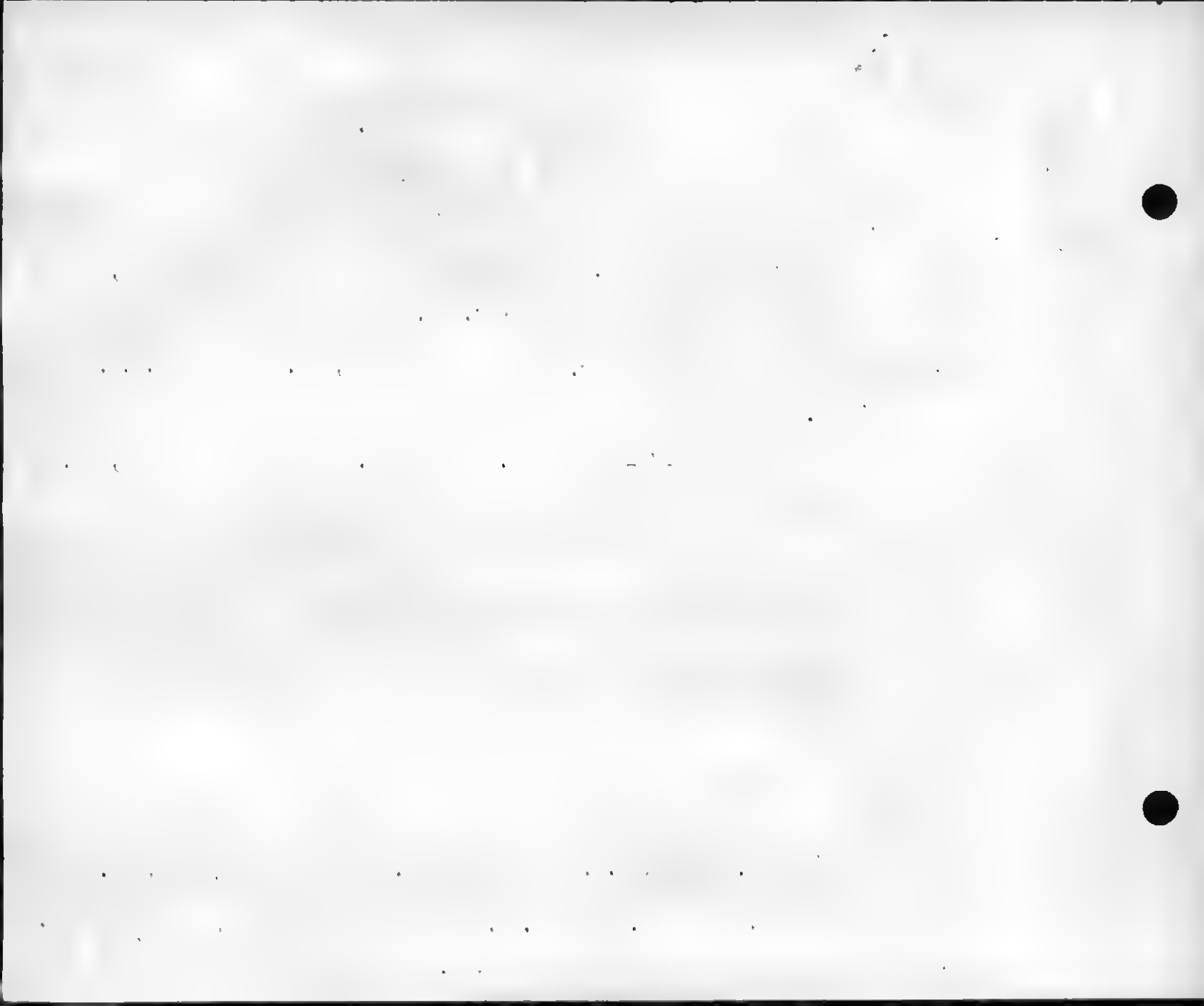
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>New Castle</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c LENGTH OF STAY IN 1b <u>7 weeks</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Andrew A. Campbell</u>		4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1988</u>	
5 SEX <u>Male</u>	6 CO. OR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Mar. 30, 1892</u>
9 AGE (In years last birthday) <u>76</u> yrs		10 IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Chemical Co.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Fair Hill, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Howett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>220-18-2869</u>	
17 INFORMANT <u>Mrs. Gertrude A. Campbell, Fair Hill, Md.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac - Respiratory Failure</u> 4409 DUE TO (and if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 days</u> <u>10 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> , 19 <u>68</u> , to <u>5-31</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>5/30</u> , 19 <u>68</u> , and that death occurred at <u>6:02 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Najera, M.D.</u>		22b. DATE SIGNED <u>5/30/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rolando A. Najera, M.D.</u>		22d. ADDRESS <u>105 E. Main Street, Elkton, Md.</u>	
23a BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 2, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns M. E. Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Lewisville Md.</u>
24 FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>June 3 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



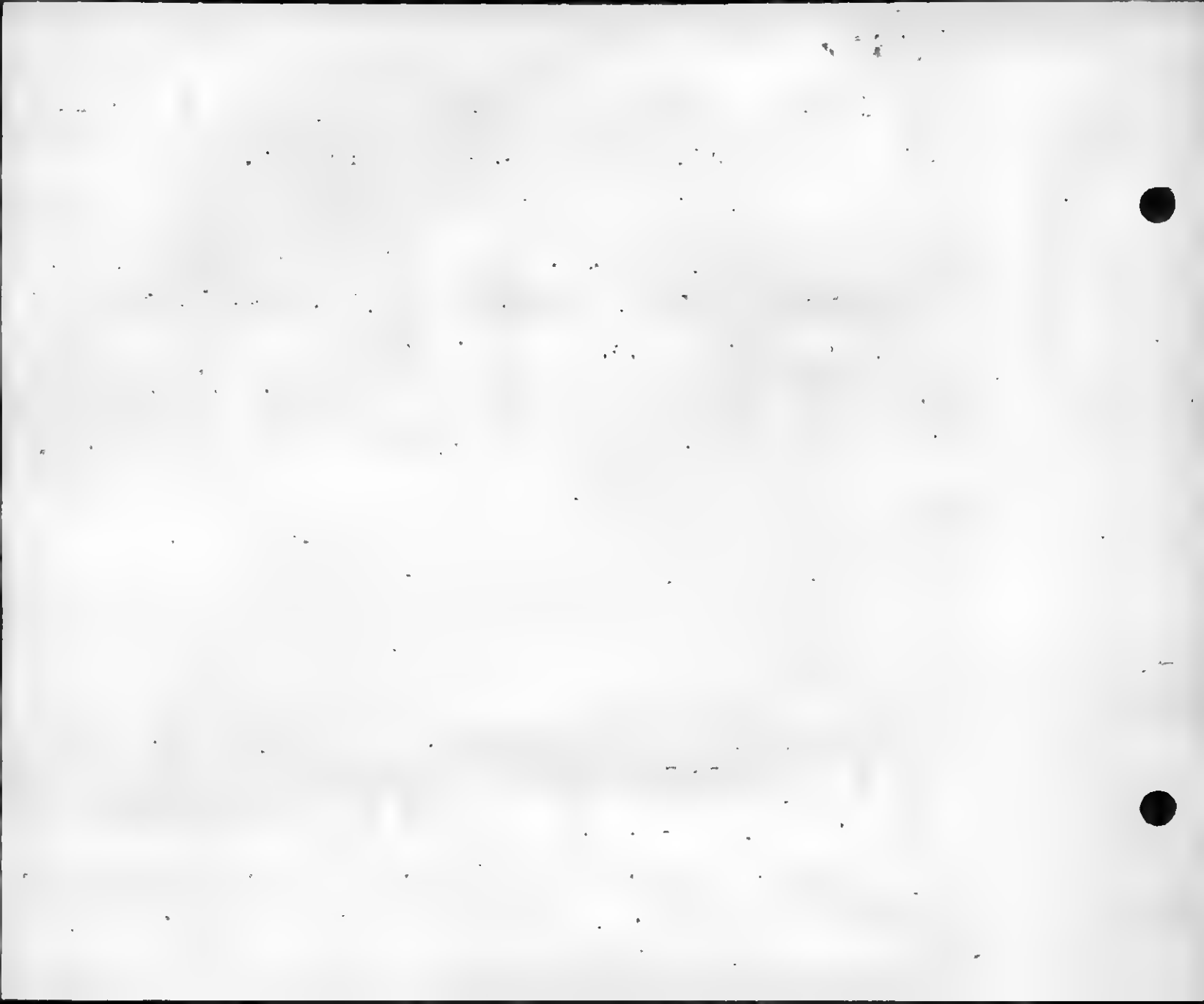
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 21 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned pages 1, 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 1514
30M REV 1-68

1
33333
MAY 21 1968
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last David Hamilton Clayton			2a. DATE OF DEATH Month Day Year May 18 1968			2b. HOUR #2 A M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH FEB. 9, 1884		6 AGE (in years last birthday) 84 YRS	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Cecil Md	
10 CITY OR TOWN OF DEATH Elkton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) LANDING LANE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RAIL ROAD		12b. KIND OF BUSINESS OR INDUSTRY RAIL	
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. STREET AND NUMBER LANDING LANE	
14 FATHER'S NAME First Middle Last DAVID CLAYTON			15 MOTHER'S MAIDEN NAME First Middle Last ELLA MARSHALL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. NONE		17 INFORMANT Address MARY V. CLAYTON ELKTON, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Failure DUE TO, OR AS A CONSEQUENCE OF (b) Internal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Rupture of Aneurism of Abdominal Aorta							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 min. 1 week 1 day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized Arterio Sclerosis with A.S. Cardio Vascular Disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 4/13/63, 19 to 5/18, 1968, that (I) (we) lost saw the deceased alive on 5-16-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Luis M. Cuza M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 5/18/68	
22d. PHYSICIAN'S NAME (Type) Luis M. Cuza, M.D.						22e. ADDRESS 322 E. Cecil Ave., North East, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 21, 1968		23c. NAME OF CEMETERY OR CREMATORY ELKTON CEMETERY		23d. LOCATION (City or Town) (County) (State) ELKTON, CEIL MD.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME, Donald Lee		ADDRESS ELKTON MD		25a. REC'D BY REGISTRAR DATE MAY 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low assures that the Death certificate is executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

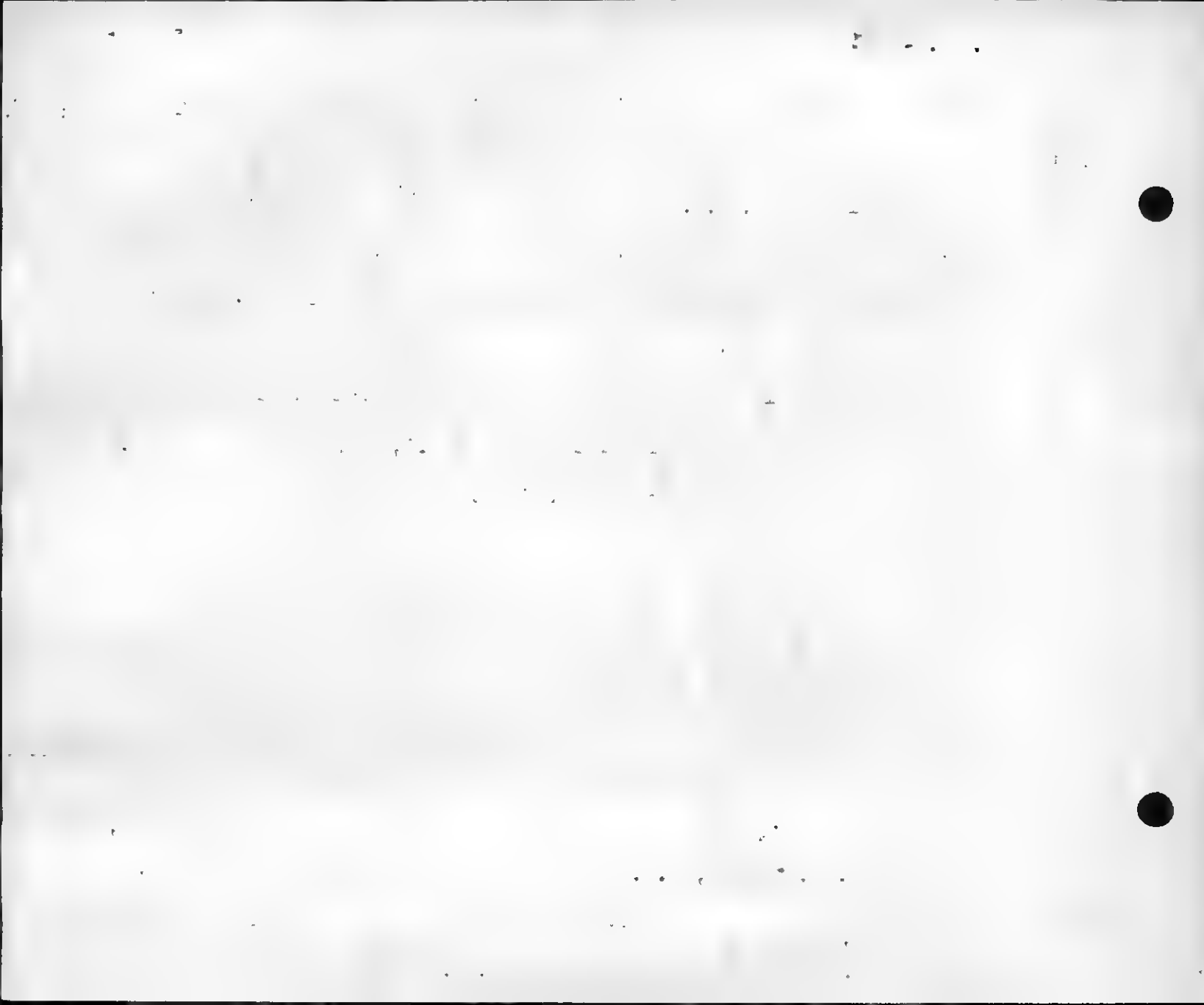
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VR A15 (4)
30M REV. 1/68

MD
233384

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last James Hull Elliott			2a. DATE OF DEATH Month Day Year May 12, 1968		2b. HOUR & MIN. 9:00
3 SEX Male	4. RACE White		5. DATE OF BIRTH June 24, 1898		6 AGE (In years last birthday) 69 YRS
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U. S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md
10 CITY OR TOWN OF DEATH Perry Point		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Draftsman	
12b. KIND OF BUSINESS OR INDUSTRY Construction		13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia		13b. COUNTY Arlington	13c. CITY OR TOWN Arlington
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3807 N. Chesterbrook Road			
14 FATHER'S NAME First Middle Last Edward R. Elliott			15. MOTHER'S MAIDEN NAME First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes give war or dates of service) NW I		16b. SOCIAL SECURITY NO. 213-38-9231		17 INFORMANT Address VA Hospital Records, Perry Point, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Pulmonary Emboli, Bilateral DUE TO, OR AS A CONSEQUENCE OF (b) Phlebothrombosis of deep leg veins DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1-1-10					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.) VA		21c. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I, VA hospital) attended the deceased from November 23 1955 , to May 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A. L. Mooney, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED May 13, 1968	
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.				22e. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	
				23d. LOCATION (City or Town) (County) (State) Alexandria, Virginia	
24 FUNERAL DIRECTOR William W. Cunningham ADDRESS WILLIAM W. CUNNINGHAM FUNERAL HOME -Alex. Va.				25a. REC'D BY REGISTRAR MAY 15 1968	
				25b. REGISTRAR'S SIGNATURE William W. Cunningham	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

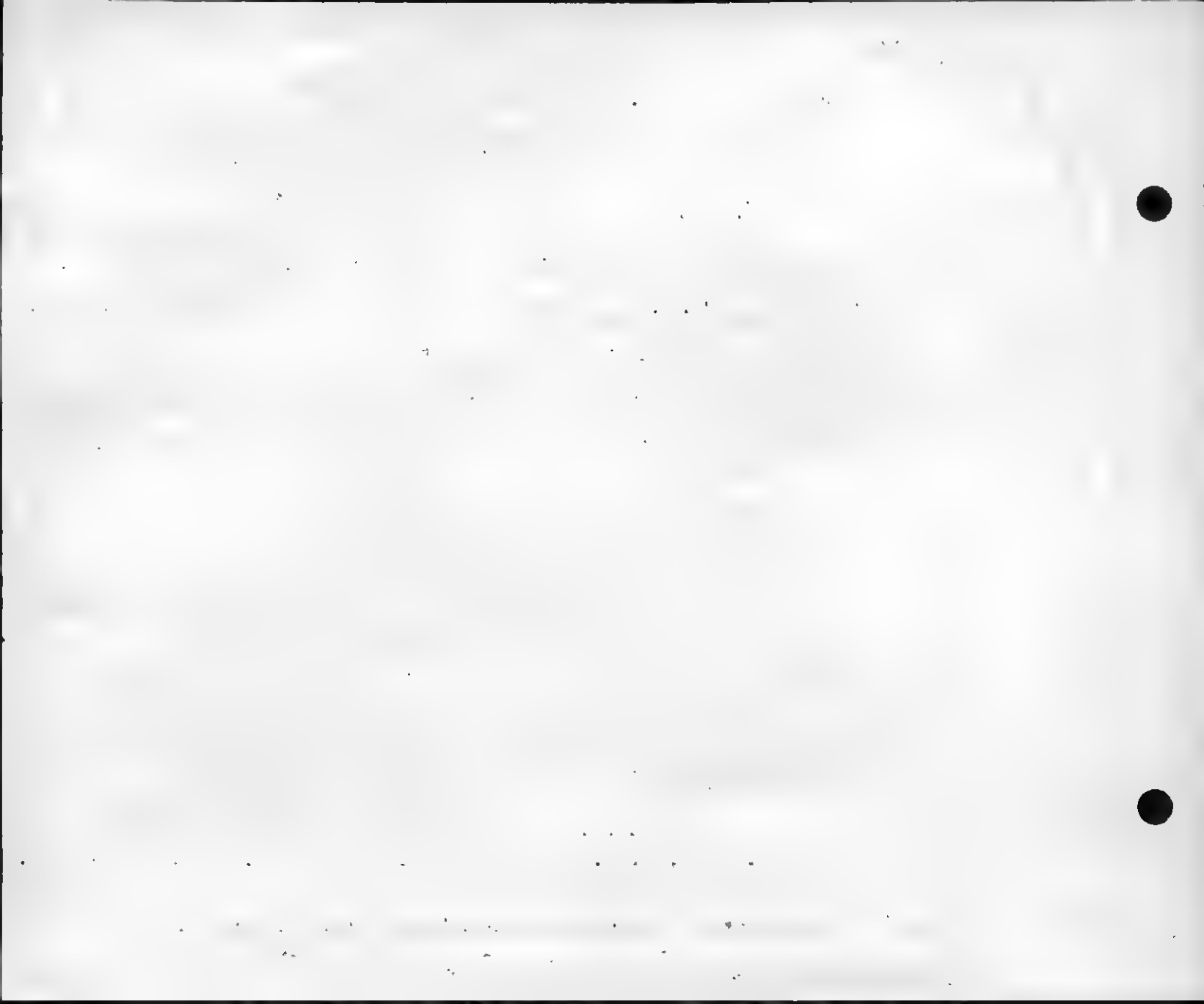
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1

10040

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Ora Middle C. Last Glenn			2a. DATE OF DEATH Month 5 Day 4 Year 68		2b. HOUR 11:45 P. M.
3. SEX m	4. RACE w	5. DATE OF BIRTH 1/6/93		6. AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Crane Operator	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Dela.		13b. COUNTY N.C.	13c. CITY OR TOWN Newark	13d. STREET AND NUMBER Maple Square Trailer Ct.	
14. FATHER'S NAME First Alexander Middle Glenn Last Glenn			15. MOTHER'S MAIDEN NAME First Elizabeth Middle Glenn Last Glenn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO. 425-09-0635A		17. INFORMANT Verna Glenn Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG. 1021 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 29 JAN , 19 68 , to present , 19 68 , that (I) (we) last saw the deceased alive on 5/4/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death					
22b. SIGNATURE Robert L. Gray				22c. DATE SIGNED 5/7/68	
22d. PHYSICIAN'S NAME (Type) Robert L. Gray, M. D.				22e. ADDRESS Elkton Medical Park, Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-7-68		23c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park	
23d. LOCATION (City or Town) Wilmington, N.C. Dela		23e. COUNTY Dela		23f. STATE Dela	
24. FUNERAL DIRECTOR William J. Marwick				25a. REC'D BY REGISTRAR -DATE 10 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. REGISTRAR'S NAME Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

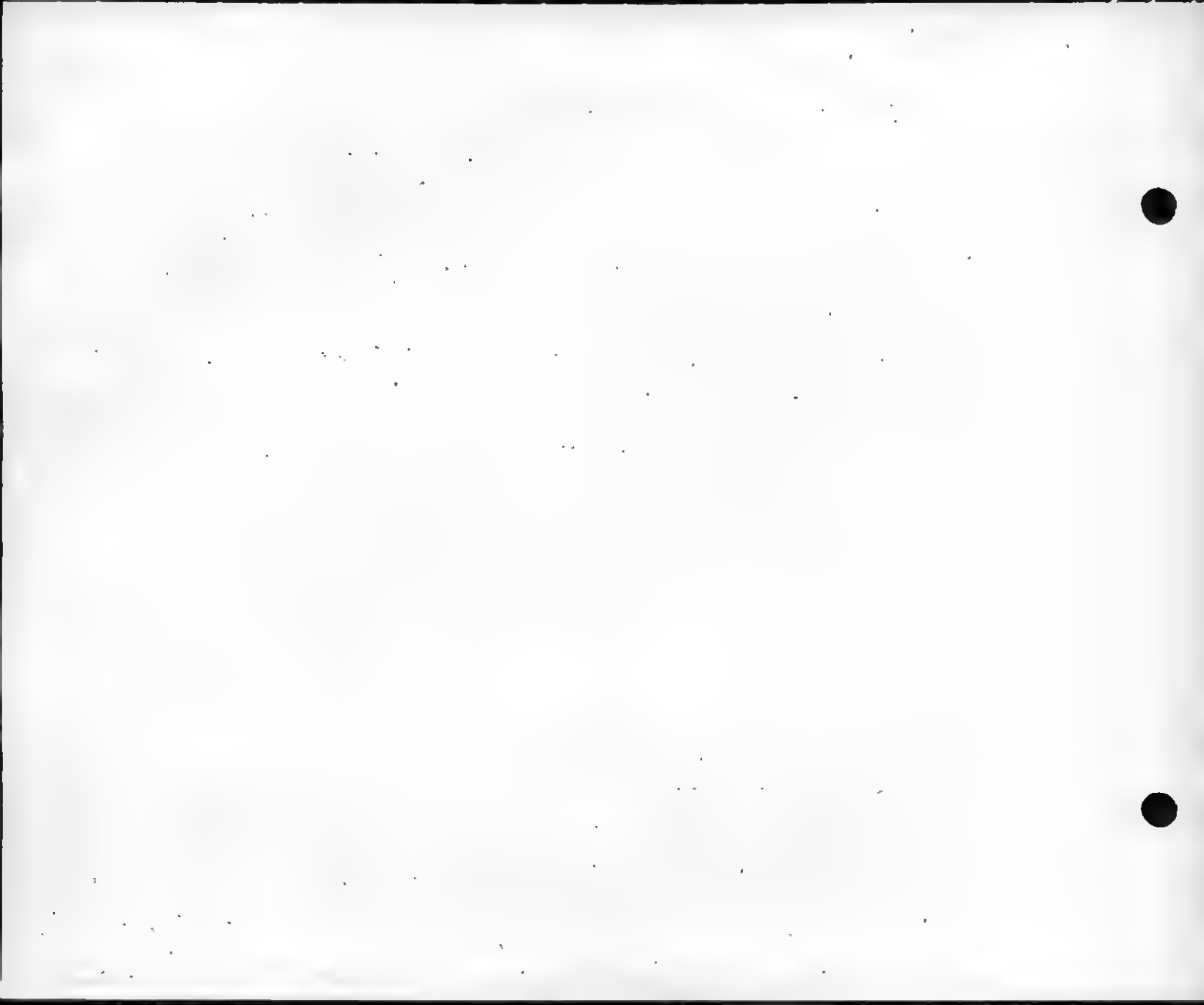
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16948

1 DECEASED NAME (Type or print) PAULINE Sister Saphronaa KASKOW		2a DATE OF DEATH Month 5 Day 22 Year 68		2b HOUR 10 P.M.
3 SEX Female	4 RACE W	5 DATE OF BIRTH 10-13 1901	6 AGE (In years last birthday) 66 YRS.	7 UNDER YEAR MONTHS 68
7a BIRTHPLACE (State or foreign country) POLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil Md.	
10 CITY OR TOWN OF DEATH Thosapeake City	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) t. Basil Crph.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Fun	12b KIND OF BUSINESS OR INDUSTRY Church	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.	13b COUNTY Cecil	13c CITY OR TOWN Thosapeake	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER
14 FATHER'S NAME First Middle Last GREGORY KASKOW	15. MOTHER'S MAIDEN NAME First Middle Last E W DUCHTA ZABROTSKY	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No 16b. SOCIAL SECURITY NO NONE 17 INFORMANT CONVENT RECORDS Address PHILA. PA.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure - one day 101X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One Day One Day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 5/21 , 19 68 , to 5/22 , 19 68 , that (I) (we) last saw the deceased alive on 5/22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death				
22b. SIGNATURE James L. Johnson	22c. DATE SIGNED 5/23/68	22d. PHYSICIAN'S NAME (Type) James L. Johnson M.D. 22e. ADDRESS 245 E. Main St., Elkhart, Ind.		
23a. BURNAL CREMATION, REMOVAL (Specify)	23b. DATE MAY 25, 1968	23c. NAME OF CEMETERY OR CREMATORY CONVENT CEMETERY	23d. LOCATION (City or Town) (County) (State) FOX CHASE MONTGOMERY PA.	
24. FUNERAL DIRECTOR PIPON FUNERAL HOME	25a. REC'D BY REGISTRAR ELKHART, IND.	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE MAY 24 1968	

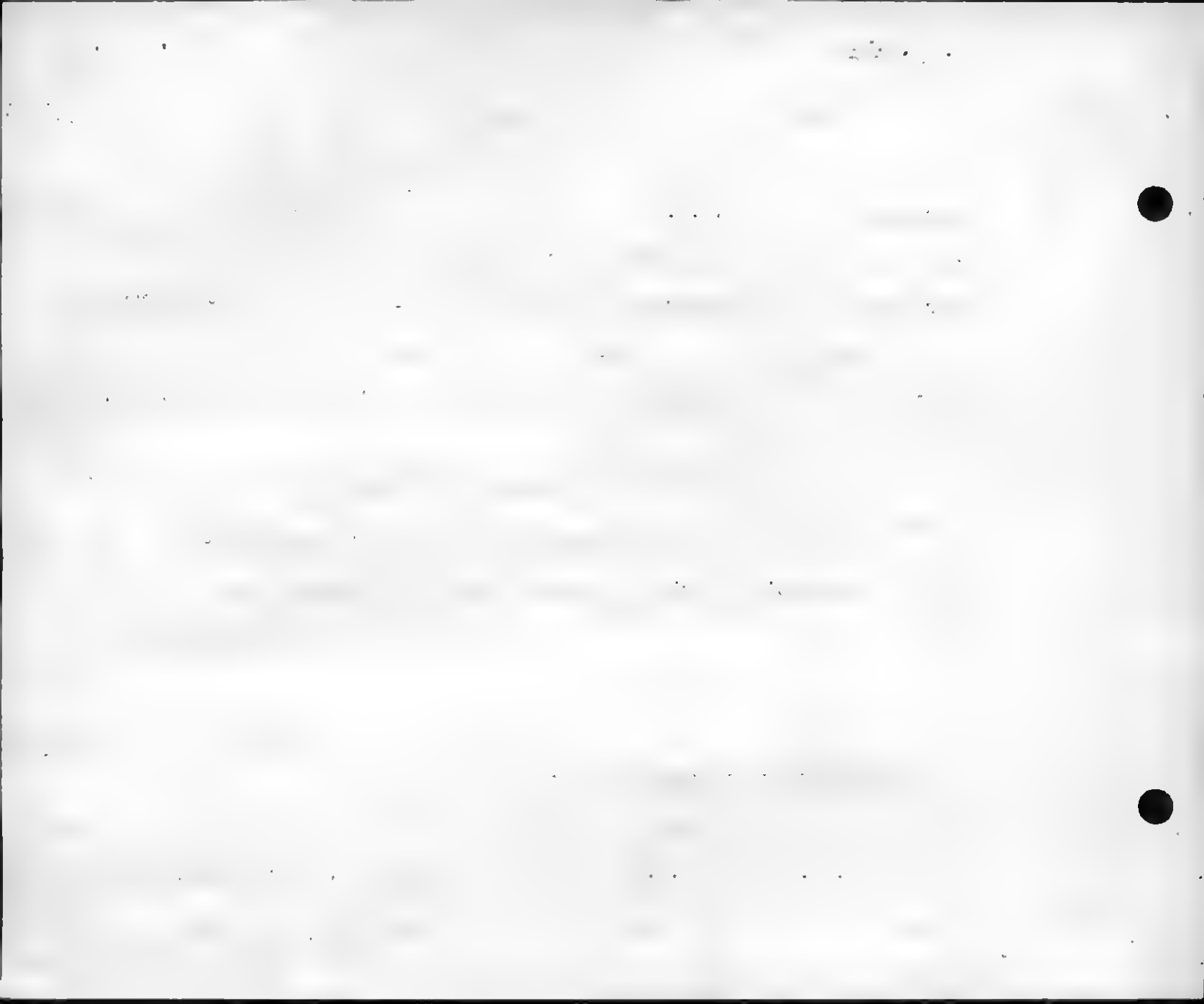


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 5:45 ^a M.	
ARTHUR C KEECH						May 5 1968				
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 6, 1895			6. AGE (In years last birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md				
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital, Perry Point, Md			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Cumberland		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 674 Fayette Street		
14. FATHER'S NAME First Middle Last Hayden Keech			15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		(If yes give year or dates of service) WW I		16b. SOCIAL SECURITY NO. 217-48-2065		17. INFORMANT Address VA Hospital Records, Perry Point, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subacute bacterial endocarditis, mitral valve</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia, both lower lobes, aspiration/</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1-2 mos</u> <u>1-2 mos</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>44X Degeneration of right occipital lobe due to subdural hematoma</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) VA			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>May 28</u> , 19 <u>68</u> , to <u>May 5</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>A. L. Mooney, M.D.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5-5-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>A. L. MOONEY, M.D.</u>						22e. ADDRESS <u>VA Hospital, Perry Point, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>5/10/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore City, Md</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore City Md</u>				
24. FUNERAL DIRECTOR <u>Ernest H. Have de Graaf, Jr.</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



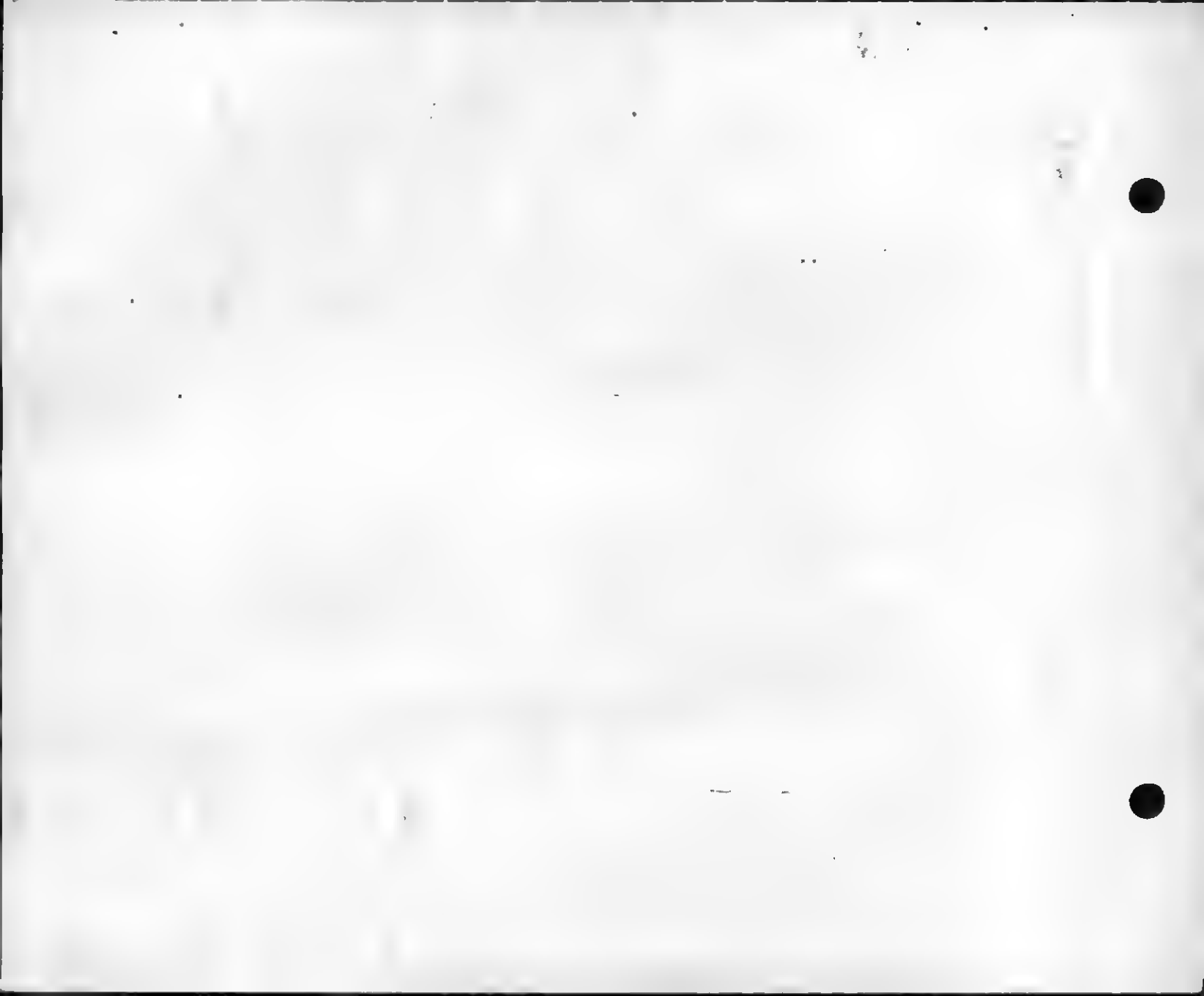
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Theodore N. Kettering			2a DATE OF DEATH Month 5 Day 20 Year 68		2b HOUR 7:20 AM
3. SEX Male	4 RACE White	5. DATE OF BIRTH 6-27-15		6 AGE (In years lost birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) MD	7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil Md.		
10 CITY OR TOWN OF DEATH Perry Point, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b COUNTY Baltimore	13c INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 3219 Keeler Rd.	
14 FATHER'S NAME First Middle Last CHARLES KETTERING			15 MOTHER'S MAIDEN NAME First Middle Last LAURA WATTS		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes		16b SOCIAL SECURITY NO 212-16-3571		17 INFORMANT Address VA Hospital, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4241 None					
19a DATE OF OPERATION None		19b CONDITION FOR WHICH OPERATION WAS PERFORMED None		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Werner Beck, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c DATE SIGNED May 20, 1968	
22d PHYSICIAN'S NAME (Type) Werner Beck		22e ADDRESS 5203 Hillwell Rd. Baltimore			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE 5/24/68	23c NAME OF CEMETERY OR CREMATORY OAK LAWN		23d LOCATION (City or Town) (County) (State) BALTO. MD	
24 FUNERAL DIRECTOR J.G. CONNELLY SONS		ADDRESS 300 MACE		25a REC'D BY REGISTRAR DATE MAY 24 1968	
25b REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



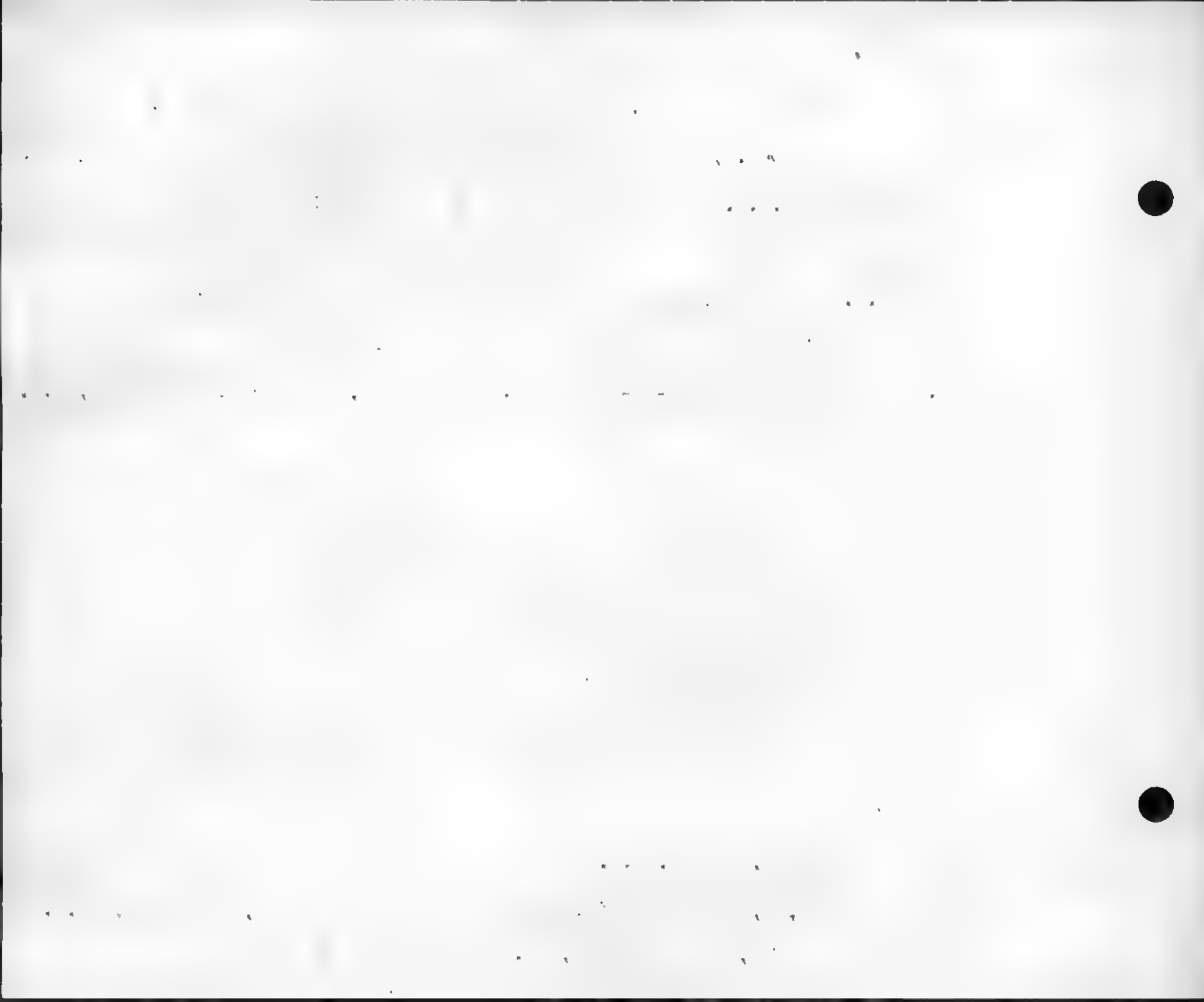
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Rolland S. Kille						Month Day Year			1:40 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS	8. MONTHS	9. DAYS	10. HOURS	11. MIN	12. DATE PRONOUNCED DEAD	13. HOUR	
Male	White	Dec. 1, 1912	55 YRS						Month Day Year	3:20 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. COUNTY OF DEATH					
New Jersey		U.S.A.		NEVER MARRIED		Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Fredricktown			None			Insurance Agent			Insurance		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
N.J.			Salem			Upper Penns Neck			397 Pine St;		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
David Kille			Florence Gibson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No.			146-05-7692			Mrs. Doris Kille			Upper Penns Neck		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
DUE TO, OR AS A CONSEQUENCE OF											
(b) CORONARY THROMBOSES										? Few hours	
DUE TO, OR AS A CONSEQUENCE OF											
(c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS.										3 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES NO					
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			2:30 P.M. 5/16/68								
21d. INJURY OCCURRED WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION (Street or R.F.D. No.)			City or Town		
NOT WHILE AT WORK									County State		
22a. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner											
Natural causes											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED		
Rolando A. Najera, M.D.						ASSISTANT MEDICAL EXAMINER			5/26/68		
						DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)		
									105 E. Main St. ELLINGTON, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			May, 29, 1968			Lawnside Cemetery			Woodstown, Salem, N.J.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Edward Fellows & Son,			Millington, Md. 21651			DATE MAY 29 1968			[Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Charles W. LINN			2a. DATE OF DEATH Month May Day 27 Year 1968			2b. HOUR a MIN 2:30			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-5-94		6. AGE (In years lost birthday) 73 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Shade Gap, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil County Md.			
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Penna.		13b. CITY Philadelphia		13c. CITY OR TOWN Phila.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 810 Delray St.	
14. FATHER'S NAME First Middle Last Samuel Linn				15. MOTHER'S MAIDEN NAME First Middle Last Lucinda Renieker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes WW I		16b. SOCIAL SECURITY NO. 716-07-25-34		17. INFORMANT Address VA Hospital Records - Perry Point, Maryland					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolus of Right Lung, massive DUE TO, OR AS A CONSEQUENCE OF (c) -----									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 465X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (s) (this hospital) attended the deceased from 5-17-68 , 19 68 , to 5-27-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. L. Mooney, M.D.				DEGREE ----- ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-27-68			
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY				22e. ADDRESS VA Hospital - Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Somerset, Penna.			
24. FUNERAL DIRECTOR Fletcher Funeral Home - Phila. Pa.				25a. REC'D BY REGISTRAR MAJ 29 1968		25b. REGISTRAR'S SIGNATURE John Judge			

03-10-10

03-10-10

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03-10-10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO NEGATIVE PHYSICAL EXAMINED

VR A15ME (5)
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <u>Jonathan E. Mann</u>						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>5</u> Day <u>10</u> Year <u>1968</u>			2b HOUR <u>9 A.M.</u>		
3 SEX <u>M</u>		4 RACE <u>C</u>		5 DATE OF BIRTH <u>5-26-1895</u>		6 AGE (In years last birthday) <u>72</u> YRS		7 UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		7 IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>	
7a BIRTHPLACE (State or foreign country) <u>Kentucky</u>			7b CITIZEN OF WHAT COUNTRY? <u>USA</u>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <u>Cecil</u>		
10 CITY OR TOWN OF DEATH <u>Perryville</u>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Cecil Ave</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired</u>			12b KIND OF BUSINESS OR INDUSTRY <u>ATG</u>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>			13b COUNTY <u>Cecil</u>			13c CITY OR TOWN <u>Perryville</u>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First <u>Edward J.</u> Middle <u>MANN</u> Last <u>MANN</u>			15 MOTHER'S MAIDEN NAME First <u>Houla B.</u> Middle <u>Daniel</u> Last <u>Daniel</u>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>			16b SOCIAL SECURITY NO. <u>UNKNOWN</u>			17 INFORMANT ADDRESS <u>Virginia C Mann, Perryville, Md.</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4127 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1968</u>											
19a. DATE OF OPERATION <u>5-10-68</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year <u>5 A.M. 5-10-1968</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <u>Natural causes</u>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) <u>Home</u>				21f. LOCATION Street or R.F.D. No <u>Maxwood Ave</u> City or Town <u>Perryville</u> County <u>Cecil</u> State <u>MD</u>			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>T. Herman D. Johnson</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>5-18-68</u>		
EXAMINER'S NAME (Type) <u>T. Herman D. Johnson M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town, or county) <u>123 Singers Ave, Elkton</u>					
23a. BURIAL, CREMATION, OR OTHER (Specify) <u>Burial</u>			23b. DATE <u>5/14/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bellview Memorial Gardens</u>			23d. LOCATION (City or Town) <u>Harford, Md.</u> (County) <u>Harford</u> (State) <u>Md.</u>			
24. FUNERAL DIRECTOR <u>Lee A. Peterson</u> ADDRESS <u>514 Perryville, Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
						DATE <u>MAY 17 1968</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
16947
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) THOMAS			First LEO			Middle MCGOWAN			Last 5			2a DATE OF DEATH Month 21 Day 68 Year 1968			2b HOUR 8:00 PM					
3 SEX M			4 RACE W			5 DATE OF BIRTH 7-9-83			6 AGE (In years last birthday) 84 YRS.			7 UNDER 1 YEAR MONTHS 0 DAYS 0			8 UNDER 24 HRS. HOURS 0 MIN. 0					
7a BIRTHPLACE (State or foreign country) Pa.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH CECIL						Md					
10 CITY OR TOWN OF DEATH ELKTON			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRESS OPERATOR			12b. KIND OF BUSINESS OR INDUSTRY SCROLL MILL											
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b COUNTY CECIL			13c CITY OR TOWN EARLVILLE			13d INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER								
14 FATHER'S NAME First JAMES			Middle MCGOWAN			Last ANNA			15 MOTHER'S MAIDEN NAME First PARKINSON			Middle EARLVILLE, MD.			Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b SOCIAL SECURITY NO 159-01-5704			17 INFORMANT MARY HILL			Address EARLVILLE, MD.											
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) Arterioxclerotic Heart Disease.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction																				
DUE TO, OR AS A CONSEQUENCE OF (b) M Myocardial Infarction															6 hours.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4221																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Shock due to Myocardial infarction.																				
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from May 1 , 19 68 , to 21 May , 19 68 , that (I) (we) last saw the deceased alive on 21 May , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b SIGNATURE Wallace Obenshain MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>															22c DATE SIGNED 21 May 68					
22d PHYSICIAN'S NAME (Type) Wallace Obenshain MD															22e ADDRESS Camden, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b DATE 5-23-68			23c NAME OF CEMETERY OR CREMATORY HARLEIGH			23d LOCATION (City or Town) (County) (State) CAMDEN N. J.											
24 FUNERAL DIRECTOR Robert Pippin ADDRESS ELKTON MD															25a REC'D BY REGISTRAR DATE MAY 23 1968			25b REGISTRAR'S SIGNATURE Robert Pippin		



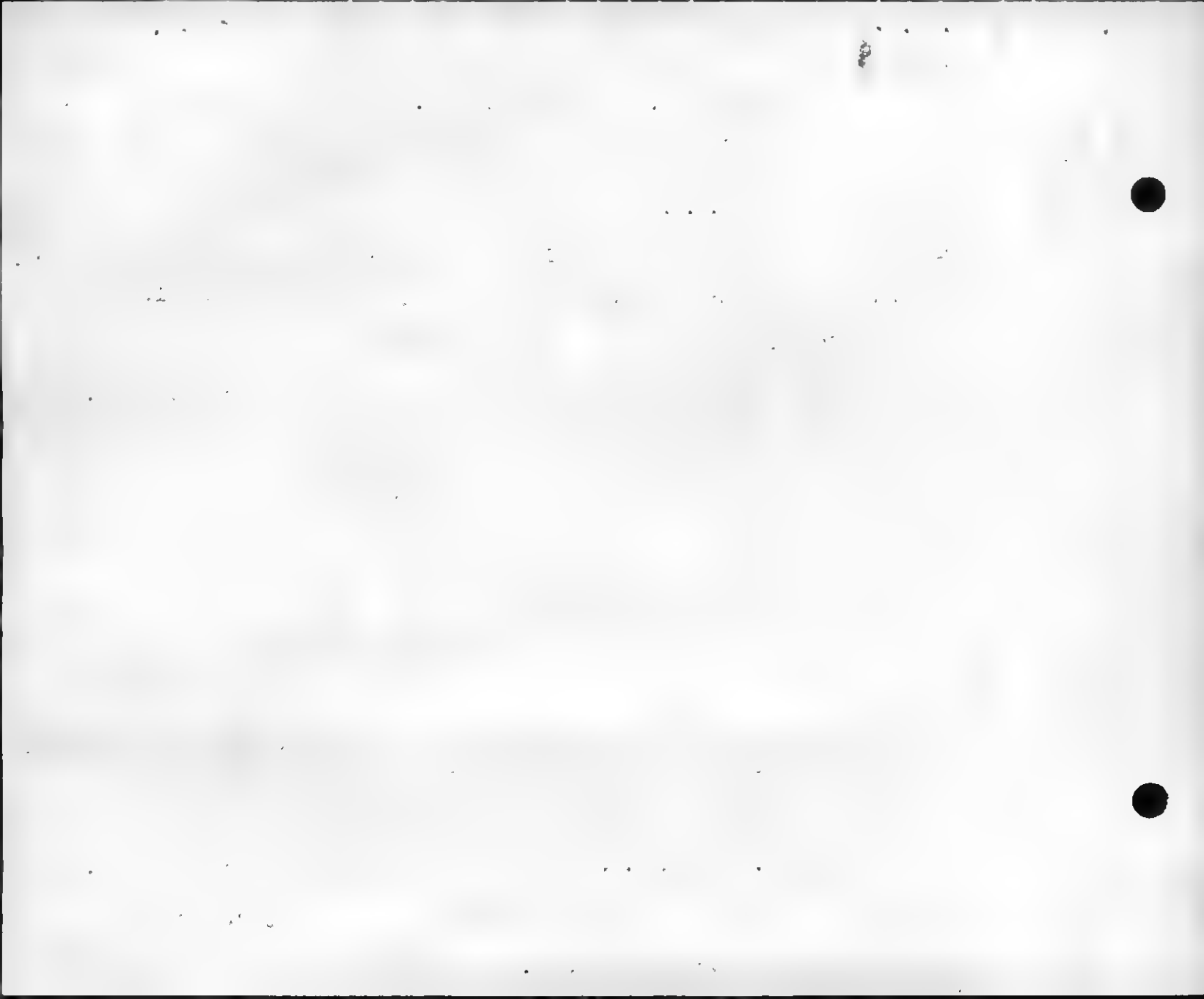
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR		
William N. MC KELVY JR.					May 25 1968		6:15a		
3. SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male	White		1-24-00		68 YRS.				
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York	U.S.A.				Cecil County		Md		
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Perry Point	VA Hospital		Brig General-Retired		Marine Corp.				
13a U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE	13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland	Prince George		Hyattsville				3000 Lancer Drive		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
William N. McKelvy		Lucy Martin							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or Unknown <input type="checkbox"/>		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
Yes 1921-1948		564-40-94-72		VA Hospital Records - Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u>								10 days	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Chronic Obstructive Bulloux Emphysema</u>								Years	
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDIT-ON FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <u>5-22-68</u> , 19 <u>68</u> , to <u>5-25-68</u> , 19 <u>68</u> and the deceased died on and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Walter D. Gundel</u> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c DATE SIGNED <u>5-25-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>WALTER D. GUNDEL, M.D.</u>								22e. ADDRESS <u>VA Hospital - Perry Point, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>5/25/68</u>		23c NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d LOCATION (City or Town) (County) (State) <u>Pt Myer, Virginia</u>			
24 FUNERAL DIRECTOR <u>Pennington & Son - Havre de Grace, Md.</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 28 1968</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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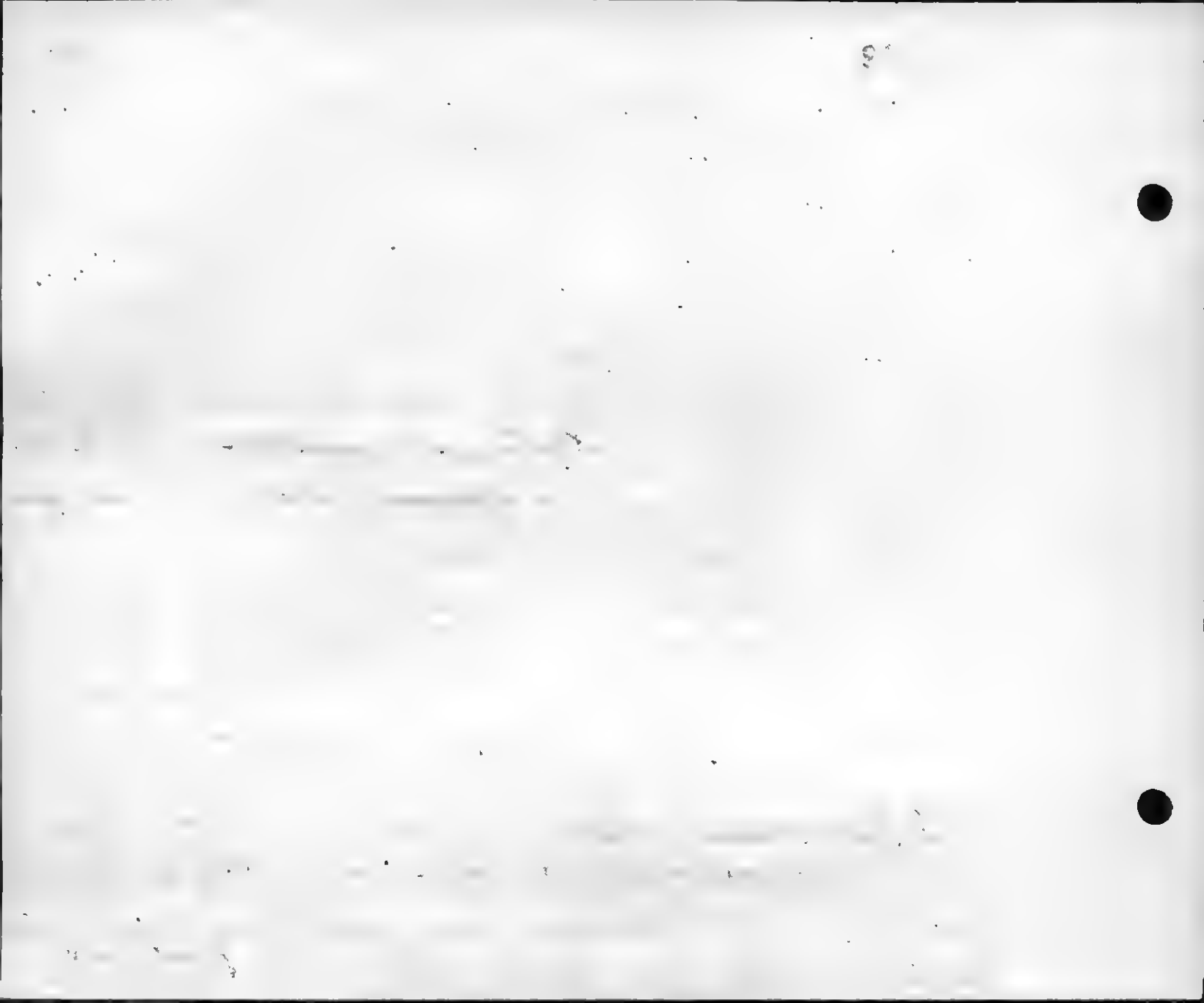


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) BAYARD LEROY MILLER			2a. DATE OF DEATH Month 5 Day 25 Year 68		2b. HOUR 4:44 PM
3. SEX MA	4. RACE W	5. DATE OF BIRTH 7-12-94		6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) CECIL, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CECIL		
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) UNION HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) FARMER	12b. KIND OF BUSINESS OR INDUSTRY FARM
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE MD.		13b. COUNTY CECIL	13c. CITY OR TOWN ELKTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 33 HOLLINGSWORTH
14. FATHER'S NAME First Middle Last JAMES MILLER		15. MOTHER'S MAIDEN NAME First Middle Last CHARA MAY BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 213-12-5174		17. INFORMANT Address BEVERLY G. MILLER ELKTON, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous pneumothorax 492 X DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema, severe DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 days many years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8-10 , 19 68 , to 5-25 , 19 68 , that (I) (we) last saw the deceased alive on 5-25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. Ralph Andrews, Jr. M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 5-29-68	
22d. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR.				22e. ADDRESS 2735 E. MAIN ST. ELKTON, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-29-68		23c. NAME OF CEMETERY OR CREMATORY ELKTON	
23d. LOCATION (City or Town) (County) (State) ELKTON CECIL MD.					
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME ELKTON ADDRESS MD.				25a. REC'D BY REGISTRAR DATE MAY 29 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last ALICE R. MOORE			2a. DATE OF DEATH Month Day Year May 4, 1968			2b. HOUR 5:55 AM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH Feb. 28, 1886		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md	
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Devine Haven Nursing Home			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elk Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Thomas Widdoes			15. MOTHER'S MAIDEN NAME First Middle Last Liza Jane Hamilton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 139-05-1651		17. INFORMANT Address F2 T. Clifford Moore, Elk Mills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4-1-1 (b) HAHD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 10 years? 10 years?							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Subacute myocarditis CVA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. INJURY OCCURRED <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/2 , 19 58 , to 5/4 , 19 68 , that (I) (we) last saw the deceased alive on 5/2 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Peter Stavrakis				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/7/68	
22d. PHYSICIAN'S NAME (Type) PETER STAVRAKIS MD				22e. ADDRESS ELKTON Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/7/68		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cemetery, Cherry Hill, Md.		23d. LOCATION (City or Town) (County) (State) Cherry Hill, Md.	
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

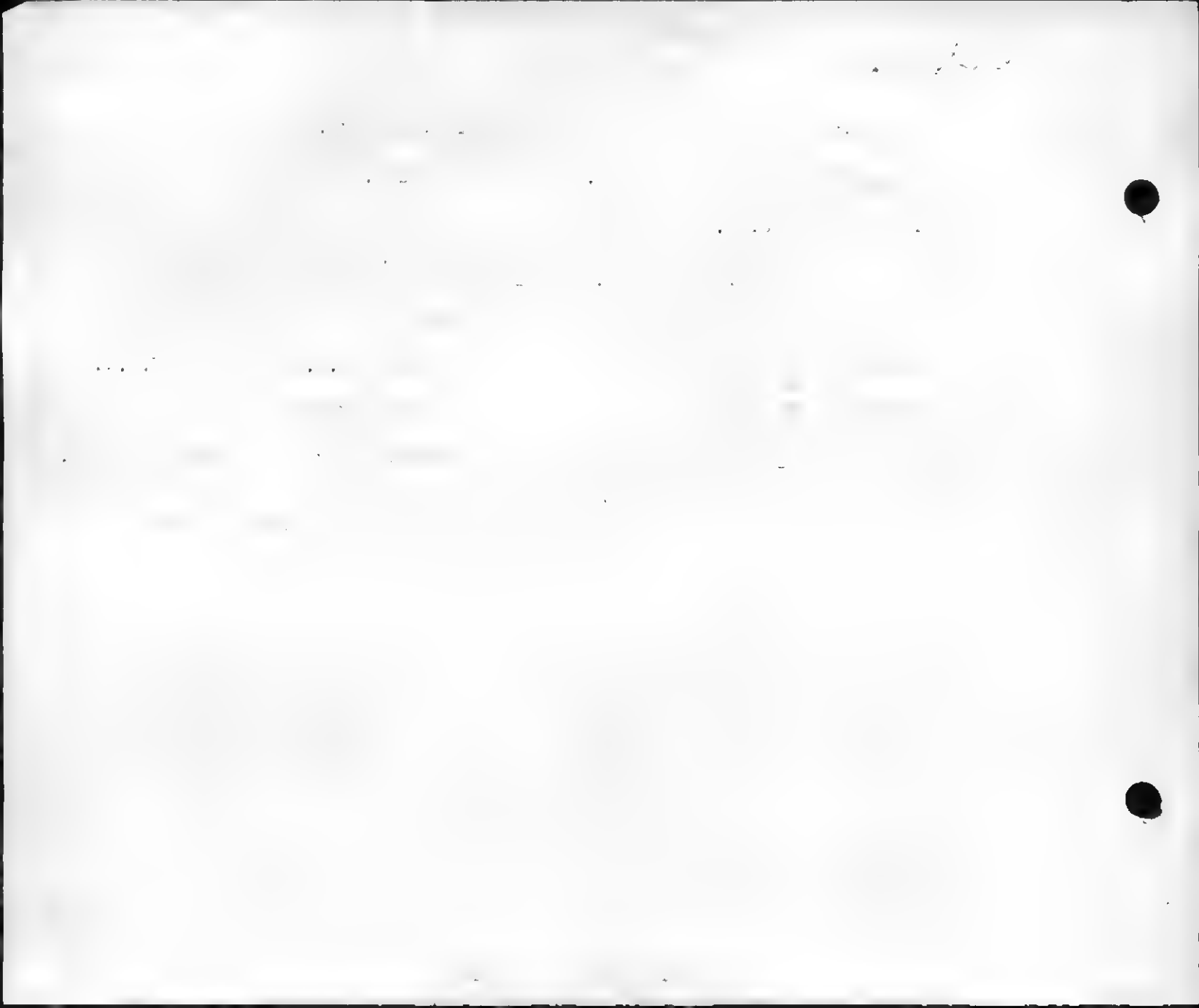
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

250

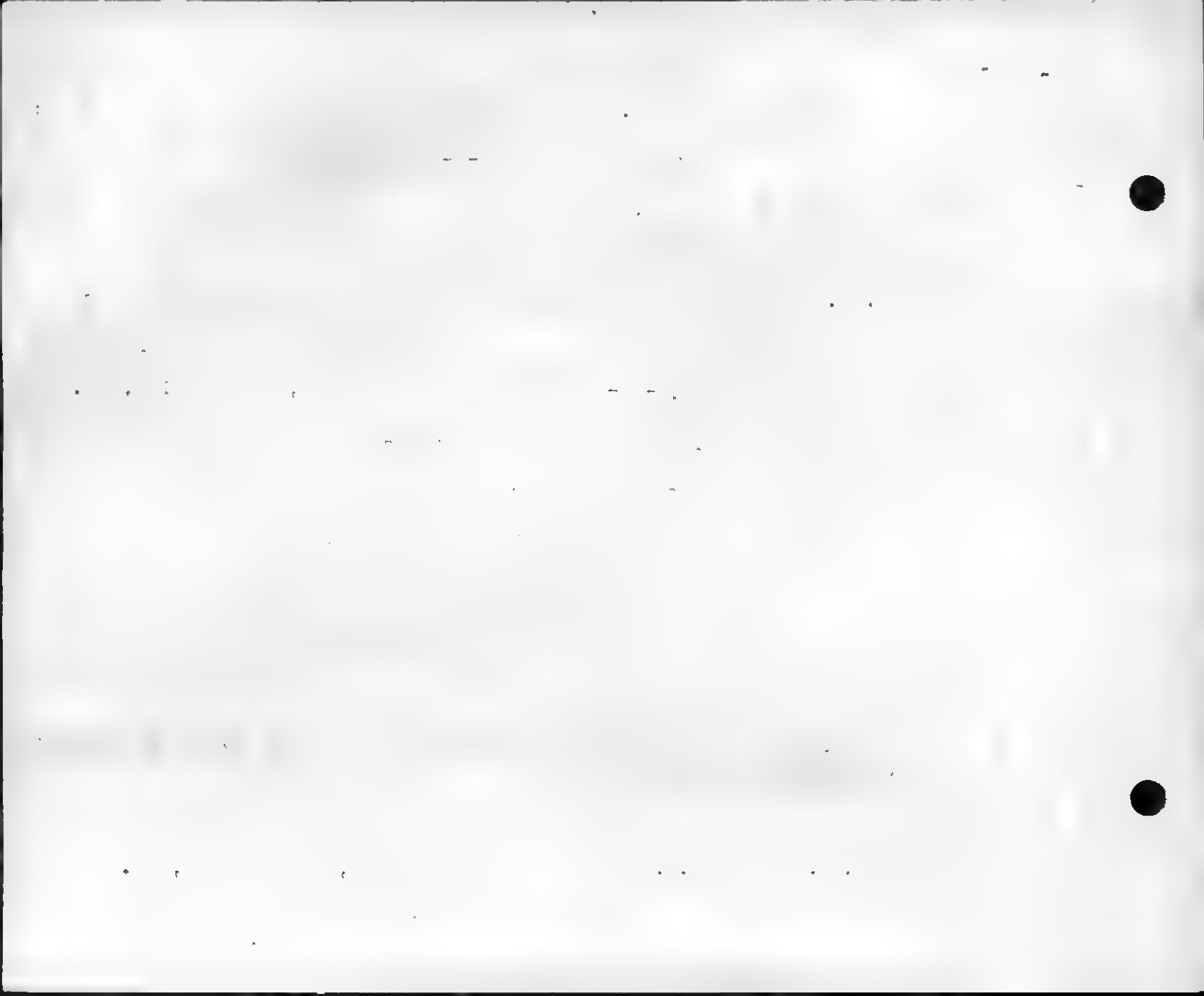
1 PLACE OF DEATH a. COUNTY Cecil MARYLAND Oneida, New York.		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Oneida, New York. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN 1b 1 Yr. 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VAH Perry Point, Md.		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Edward Middle L. Last Moran		4 DATE OF DEATH Month May Day 31 Year 19 68	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-27-17
9 AGE (In years and months) 50 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11 BIRTHPLACE (State or foreign country) Oneida, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Moran	
14. MOTHER'S MAIDEN NAME Goldie Torrey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2	
16 SOCIAL SECURITY NO 263-24-5718		17. INFORMANT VA Hospital Records Address Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema acute 4129 DUE TO Severe Arteriosclerotic coronary heart disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 426			19 WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Henry V. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) HENRY V. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 5/3/68		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BIRTHAL CREMATION OR BURIAL (Specify)		23b. DATE THEREOF 5/6-6-68	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.		23d. LOCATION (City or town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR W. J. Johnson Jr., Perryville, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JUN 11 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
I+ema#526, Film#0400 5/24/68 km CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
ROBERT L. MURPHY						Month 5 Day 10 Year 68		10:15 am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
Male		Negro		8-11-18 8-31-18		51 1/2 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. M.D.		
South Carolina		USA				Cecil				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point		Veterans Administration		Laborer						
13a. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D. C.					Washington		YES <input type="checkbox"/> NO <input type="checkbox"/>		515 Hill Top Terrace	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Robert Murphy			Bessie Fridaybugh							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
Yes			WW II		579-16-1740 VA Hospital Records, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple pulmonary infarets									36-48 hrs	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Massive pulmonary embolus										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Phlebothrombosis of deep leg veins										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (this hospital) attended the deceased from May 3, 19 68, to May 10, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A. L. Mooney, M.D.								22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.								22e. ADDRESS VA Hospital, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Removal		5-15-68		Harmony Memorial Park		Prince George, Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Rheus Funeral Home 3015-12 07E.				DATE MAY 16 1968		Charles Judge				



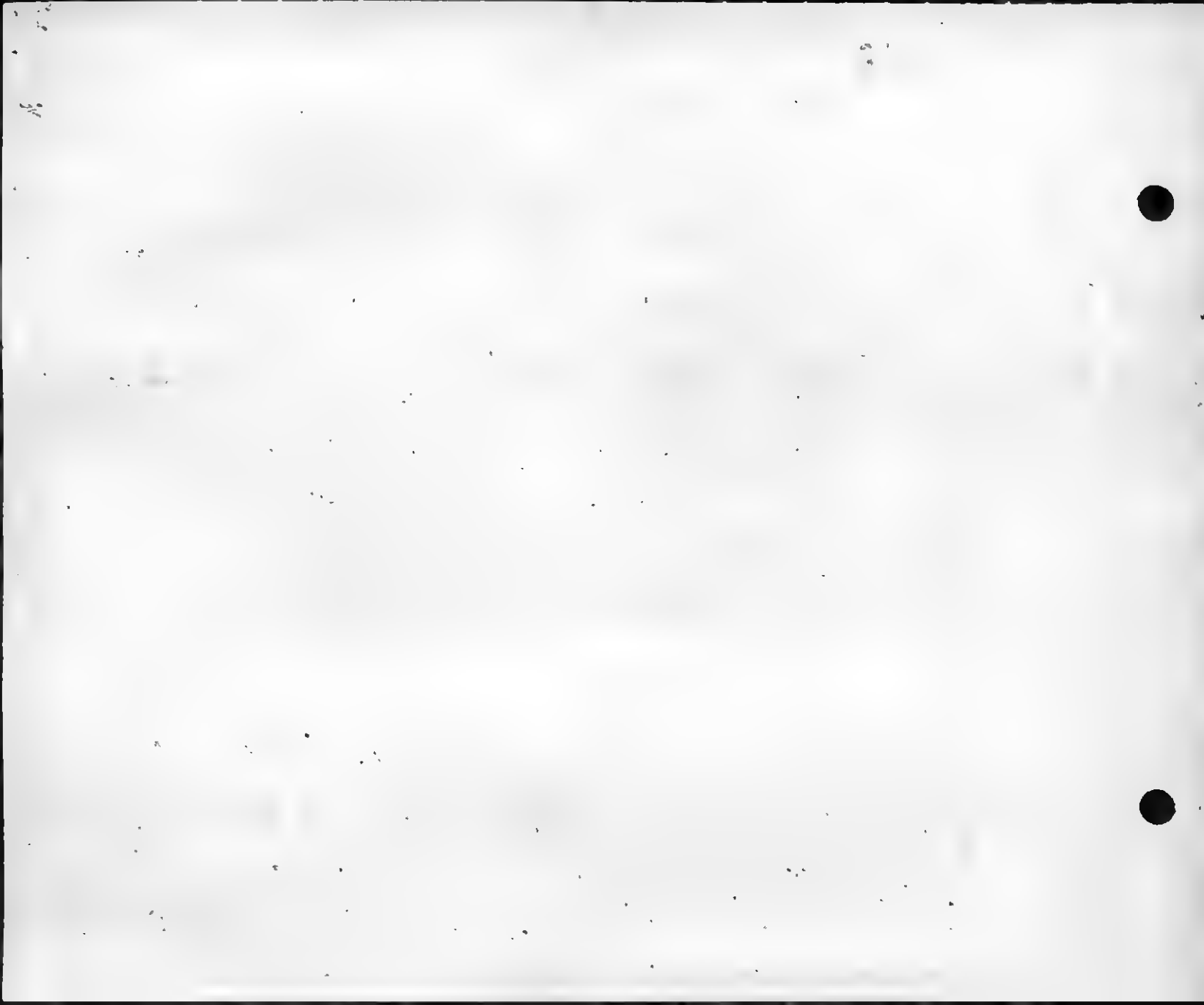
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First Ernest Lealand Ott			Middle			Last			2a. DATE OF DEATH May Month 27 Day 1968 Year			2b. HOUR 4:15 PM		
3 SEX Male			4. RACE White			5. DATE OF BIRTH July 14, 1891			6. AGE (In years last birthday) 76 YRS			7. UNDER YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Cecil Md								
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming								
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland			13b. COUNTY Cecil			13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 106 Normira ST.					
14. FATHER'S NAME First Middle Last J. Allen Ott			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Jones														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes			16b. SOCIAL SECURITY NO WW 1 214- 03-0569			17. INFORMANT Leonard Clayton			Address 106 Normira St. Elkton, Md.								
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE CEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE C.V.D. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS 15 YRS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from JULY 10, 1946, to MAY 27, 1968, that (I) (we) last saw the deceased alive on MAY 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE Henry J. Davis MD			22c. DATE SIGNED 5/28/68			22d. PHYSICIAN'S NAME (Type) HENRY J. DAVIS MD			22e. ADDRESS CHESAPEAKE CITY MD								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 5-28-68			23c. NAME OF CEMETERY OR CREMATORY V. Md. Med. School			23d. LOCATION (City or Town) (County) (State) BALTIMORE MD								
24. FUNERAL DIRECTOR GREGORY FOWLER HOWE			25a. REC'D BY REGISTRAR DATE MAY 31 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											

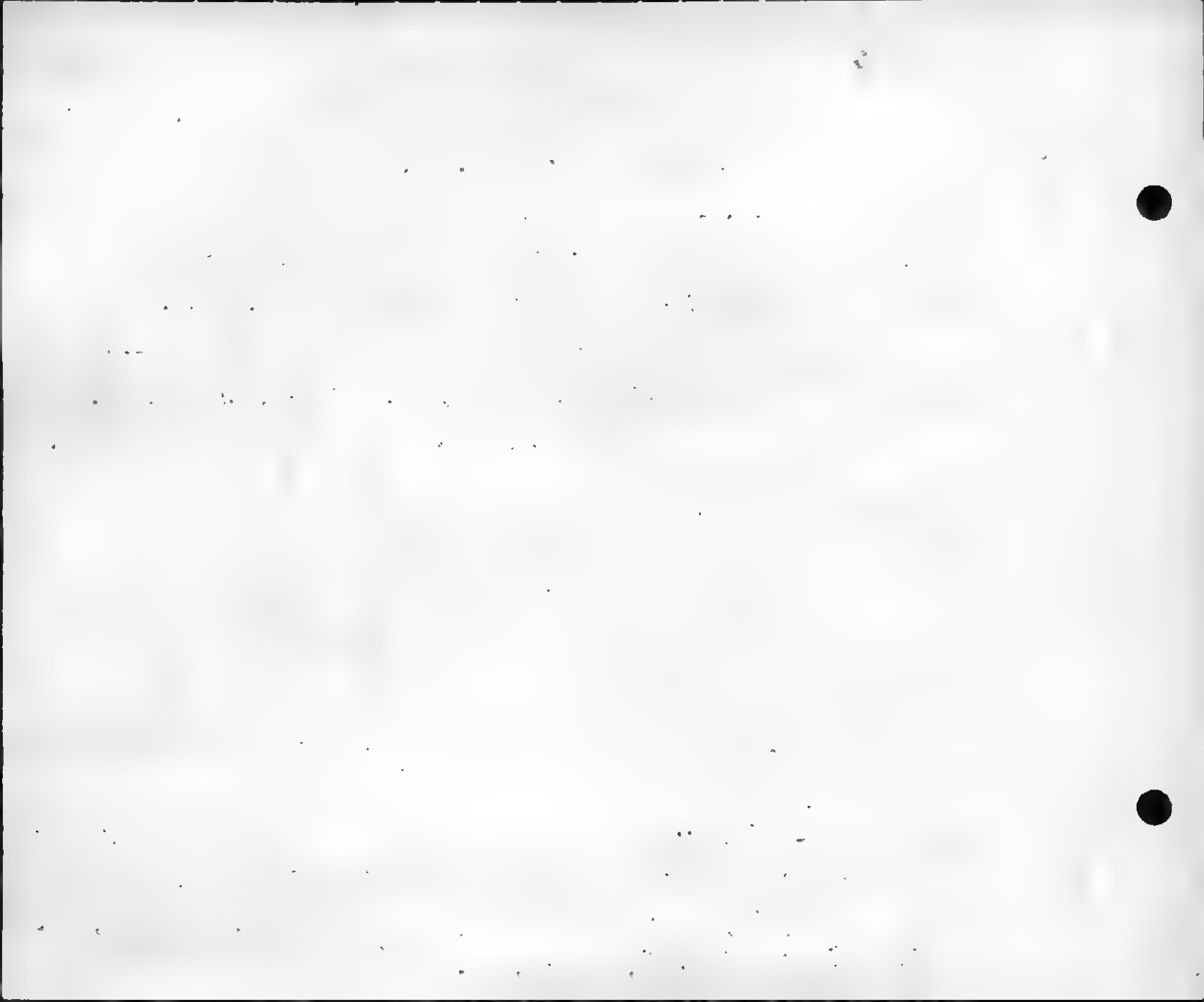


Page 4 may be retained by the hospital or attending physician.

A15(4)
REV Y/8

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR	
James		Henry		Painter				May		5		1968		4 P.		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS HOURS		9. IF UNDER 24 HRS MIN.					
Male		White		Feb. 23, 1896		72		YRS									
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
Virginia		U.S.A.				Cecil											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USOA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Elkton		Union Hospital		Laboring Work													
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER									
Maryland		Cecil		Elkton				114 Bow St.									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Joseph		Painter						Ida									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address											
No		218-12-3599		Joseph F. Painter, Elkton, Md.													
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5 MAY</u> , 19 <u>68</u> , to <u>5 MAY</u> , 19 <u>68</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>5 MAY</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.																	
22b. SIGNATURE <u>Robert L. Gray</u>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>8 MAY 1968</u>							
22d. PHYSICIAN'S NAME (Type)		Robert L. Gray		22e. ADDRESS <u>Elkton Medical Park</u>													
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <u>5/11/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Cemetery</u>		23d. LOCATION (City or Town)		(County)		(State)							
Burial						<u>Elkton</u>		<u>Cecil Co.</u>		<u>MD.</u>							
24. FUNERAL DIRECTOR <u>Joseph E. Hicks</u>		ADDRESS <u>Hicks Home for Funerals, Elkton, Md.</u>		25a. REC'D BY REG. STAFF <u>MAY 15 1968</u>		25b. RECORDED BY <u>James</u>											

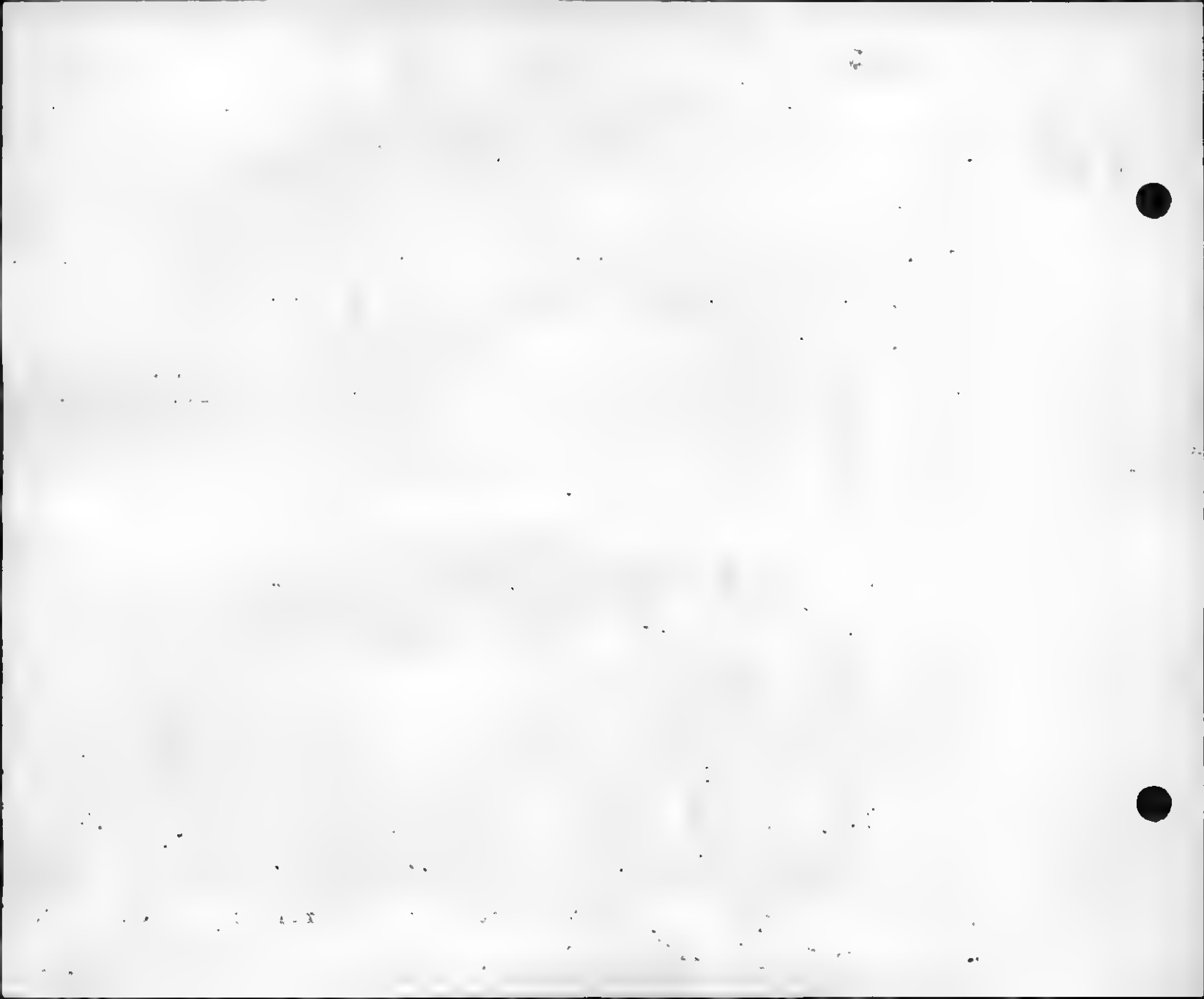


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Howard K. Purcell			2a. DATE OF DEATH Month 5 Day 27 Year 68			2b. HOUR 4 A. M.				
3 SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 26, 1895		6. AGE (in years last birthday) 72 YRS		F UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md				
10. CITY OR TOWN OF DEATH North East			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) R.D. 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Sand & Gravel	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D. 2	
14. FATHER'S NAME First Middle Last George Purcell				15. MOTHER'S MAIDEN NAME First Middle Last Ruth Green						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (or, no, or unknown) WW I			16b. SOCIAL SECURITY NO 215-10-7304		17. INFORMANT Edna J. Purcell			Address R.D. 2 North East, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion with Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last <u>4201</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 5 yrs										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of prostate with metastasis; Hypertrophic osteoarthritis;</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from Oct, 1966, to 27 May, 1968, that (I) (we) last saw the deceased alive on 25 May, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.										
22b. SIGNATURE Klaus H. Huebner M.D.				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 5/27/68		
22d. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER				22e. ADDRESS NORTH EAST, Md						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-29-68		23c. NAME OF CEMETERY OR CREMATORY North East, Methodist			23d. LOCATION (City or Town) (County) (State) North East Cecil Md.			
24. FUNERAL DIRECTOR Grant Funeral Home				ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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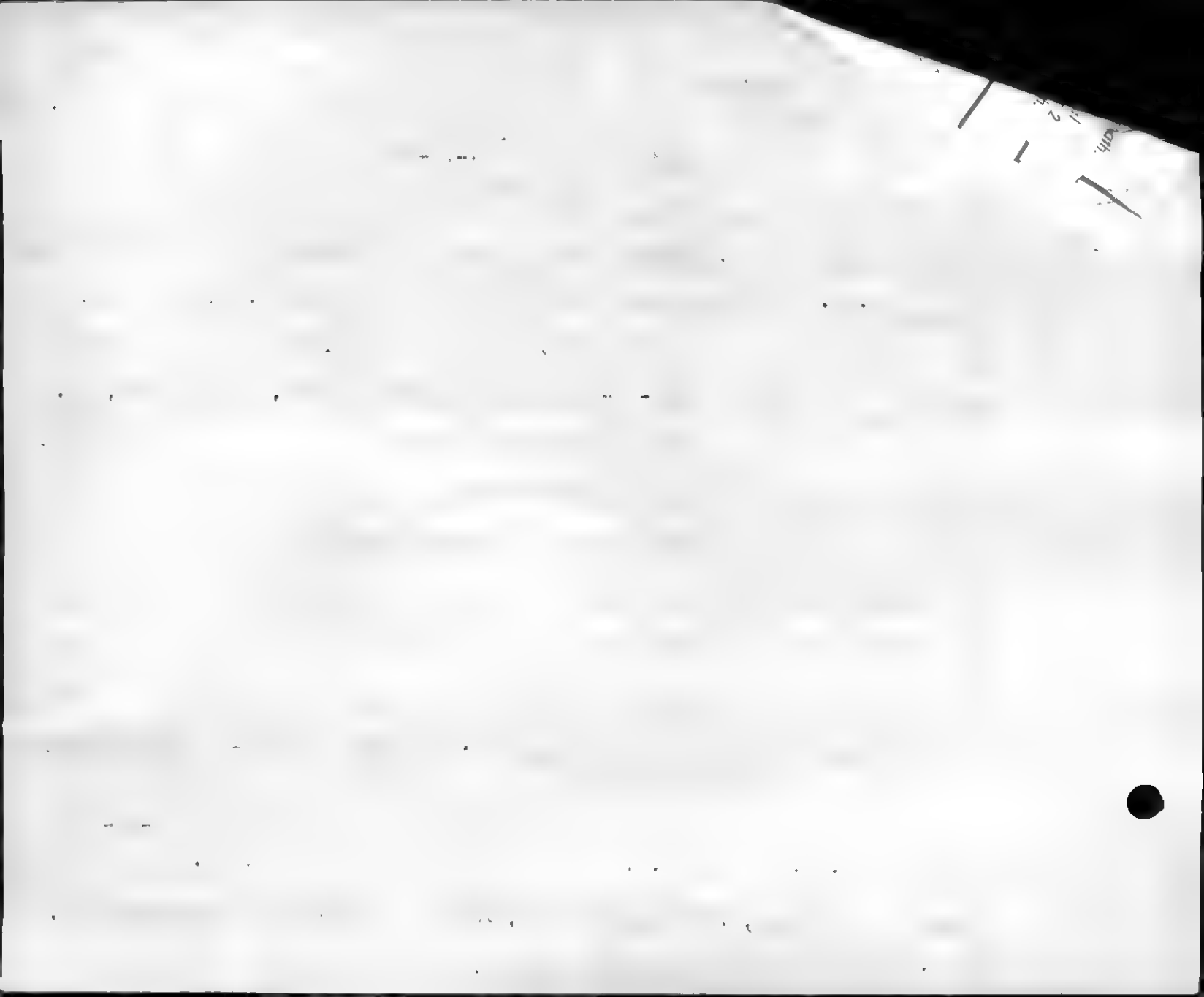
MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #11 & 23b Film #G400 5/21/68									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY CECIL MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) RISING SUN			c. LENGTH OF STAY IN 1b 13 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS REYNOLDS AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First F. MARION Middle RAWLINGS Last					4. DATE OF DEATH Month MAY Day 19 Year 1968				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 2, 1912		9. AGE (in years lost birthday) 55 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POST MASTER		10b. KIND OF BUSINESS OR INDUSTRY POST OFFICE		11. BIRTHPLACE (County & State or foreign country) Rising Sun, Md			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME FRANCIS M. RAWLINGS					14. MOTHER'S MAIDEN NAME GEORGIE McMASTER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO 216-05-8932		17. INFORMANT Address LOUISE RAWLINGS, RISING SUN, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction +104 DUE TO (b) Coronary Insufficiency Conditions, if any/which gave rise to immediate cause (a), stating the underlying cause lost. (c)								INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 , 19 67 , to 5-19 , 19 68 , that (I) (we) last saw the deceased alive on 5-18 , 19 68 , and that death occurred at 4A M, from causes and on the date stated above									
22a. SIGNATURE Neil R Taylor Jr M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 5-20-68			
22c. PHYSICIAN'S NAME (Type) Neil R Taylor Jr						22d. ADDRESS Rising Sun, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/21/68		23c. NAME OF CEMETERY OR CREMATORY BROOKVIEW CEMETARY		23d. LOCATION (City or Town) (County) (State) RISING SUN, CECIL MD			
24. FUNERAL DIRECTOR RALPH M. REED ADDRESS Ralph M Reed RISING SUN, MD						25a. REC'D BY REGISTRAR DATE MAY 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

DECEASED NAME (Type or print) William WILLIAM		First William	Middle H	Last REEVES	2a. DATE OF DEATH Month 5 Day 11 Year 68		2b. HOUR 5:15p
3. SEX Male	4. RACE White		5. DATE OF BIRTH 4-18-08		6. AGE (In years last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN _____
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil Md		
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Packer		12b. KIND OF BUSINESS OR INDUSTRY Glass	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE N. J.		13b. COUNTY Cumberland		13c. CITY OR TOWN Millville	13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 400 W. McNeal Street	
14. FATHER'S NAME First William Middle _____ Last Reeves (D)			15. MOTHER'S MAIDEN NAME First Adeline Middle _____ Last Flowers (D)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO 146-07-7018		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year 19 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from Jan. 22, 1968 , to May 11, 1968 , that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. L. Mooney, M.D.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-13-68	
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.				22e. ADDRESS VAH, Perry Point, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE May 15, 1968		23c. NAME OF CEMETERY OR CREMATORY Greenwood Mem. Park		23d. LOCATION (City or Town) (County) (State) Millville Cumberland Md.	
24. FUNERAL DIRECTOR LEE A. PATTERSON FUNERAL HOME, PERRYVILLE, MD				25a. REC'D BY REGISTRAR MAY 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR 415
30M REV 1/68

MIDDLE										LAST										20 DATE OF DEATH										26 HOUR																																																	
Edward Charles Reynolds										Middle										May 1 1968										9:57 AM																																																	
4 RACE										5 DATE OF BIRTH										6 AGE (In years last birthday)										IF UNDER 1 YEAR										IF UNDER 24 HRS																																							
Male										White										Jan. 25, 1918										5 YRS										MONTHS										DAYS										HOURS										MIN.									
7a BIRTHPLACE (State or foreign country)										7b CITIZEN OF WHAT COUNTRY?										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>										9 COUNTY OF DEATH																																																	
Maryland										USA										WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										Cecil																																																	
10. CITY OR TOWN OF DEATH										11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b KIND OF BUSINESS OR INDUSTRY																																																	
Elkton										Union Hospital										Electrician										Civil Service																																																	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b COUNTY										13c CITY OR TOWN										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET AND NUMBER																																							
Maryland										Cecil										North East																				111 East Harvey St.																																							
14 FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																																					
Melvin L. Reynolds										Helen Lockard																																																																					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)										16b SOCIAL SECURITY NO.										17 INFORMANT										111 E. Harvey St. North East, Md.																																																	
Yes										WW 2										716-01-6397										Ruth G. Reynolds																																																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										Acute myocardial infarction.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
										DUE TO, OR AS A CONSEQUENCE OF										(b) Arteriosclerotic cardiovascular disease.																																																											
										DUE TO, OR AS A CONSEQUENCE OF										(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																																	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																											
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)										21c LOCATION Street or R.F.D. No City or Town County State																																																											
22a. I certify that (1) (this hospital) attended the deceased from Dec. 1963, to May 1968, that (1) (we) last saw the deceased alive on 4-25-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																																																																															
22b SIGNATURE Jay S. Barnhart, Jr. M.D. DEGREE										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED 5-2-68																																																											
22d. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.										22e. ADDRESS 4 Mauldin Ave. North East, Md.																																																																					
23a BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 5-4-68										23c. NAME OF CEMETERY OR CREMATORY North East Methodist										23d LOCATION (City or Town) Cecil (County) Md. (State)																																																	
24. FUNERAL DIRECTOR Grant Funeral Home										ADDRESS 22 North East, Md.										25a. REC'D BY REGISTRAR MAY 6 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																																																	

MARYLAND
DIVISION OF VITAL RECORDS

DECEASED NAME
(Type or print)

3 SEX

1
M

By the funeral
homes 1 and 2
offer with
ours offer death

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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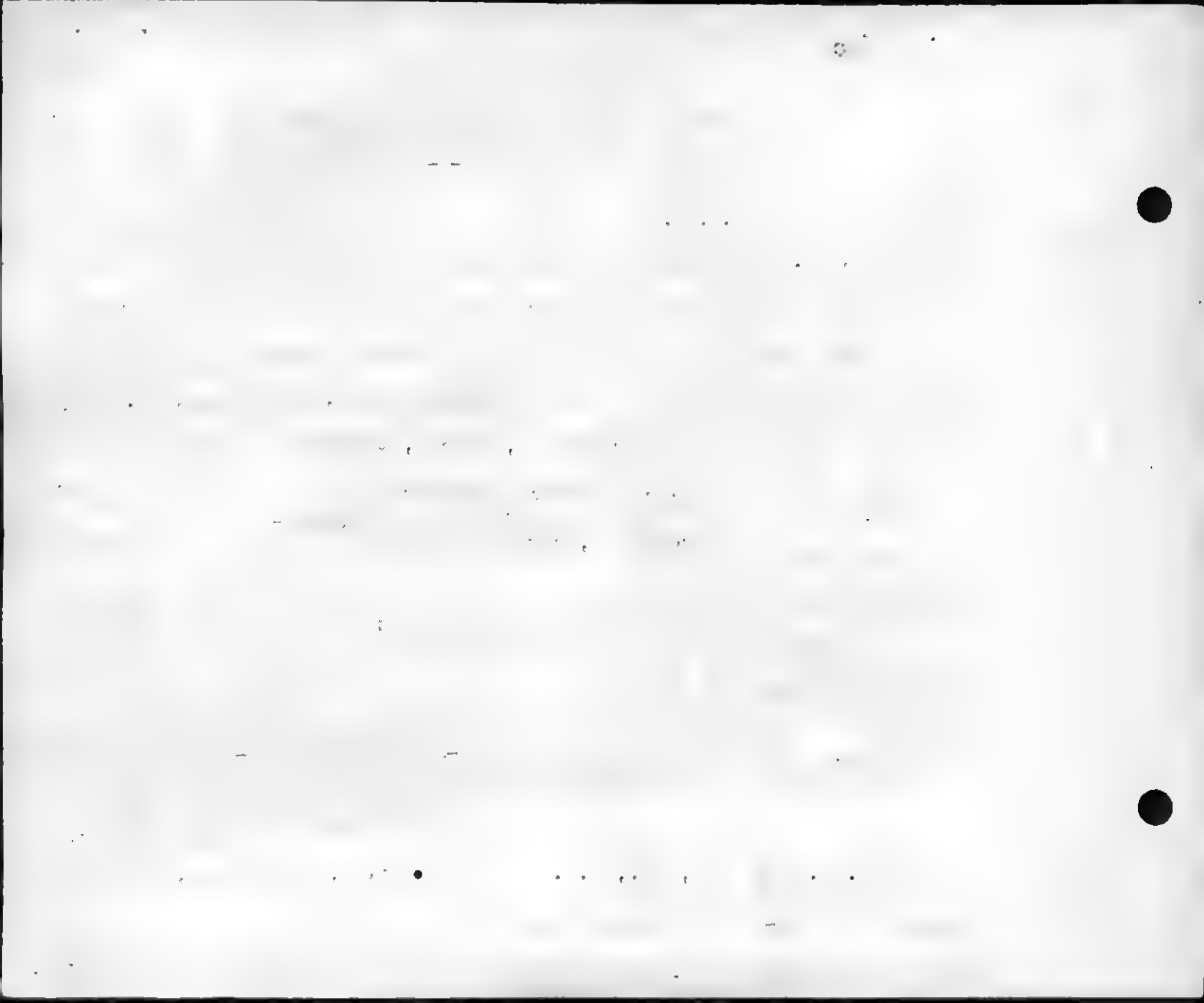
VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b. HOUR P M		
ROBERT MOSES RIVERS						May 5 1968			4:15 PM		
3. SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
Male	Negro	11-7-11		56 YRS							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Cecil Md.					
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point, Md.		VA Hospital, Perry Point		Laborer							
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER					
Va		Fairfax		Alexandria		1202 Princess Street					
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Thomas Rivers						Georgia Turner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
yes		578 03 7999		VA Records		VAH, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, severe, terminal</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Cortical Degeneration</u>									<u>3 years</u>		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Brain Syndrome -</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (1) (this hospital) attended the deceased from <u>3-25, 1968</u> , to <u>5-5, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>T. R. Huxtable, Jr.</u>		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>5-6-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>T. R. HUXTABLE, JR., M.D.</u>		22e. ADDRESS <u>VA Hospital, Perry Point, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-6-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Coleman</u>		23d. LOCATION (City or Town) (County) (State) <u>Fairfax Co. Va</u>					
24. FUNERAL DIRECTOR <u>R.W. Poole</u>		ADDRESS <u>Arnold Funeral Home, 311 N. Patrick St</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

Alexandria, Virginia

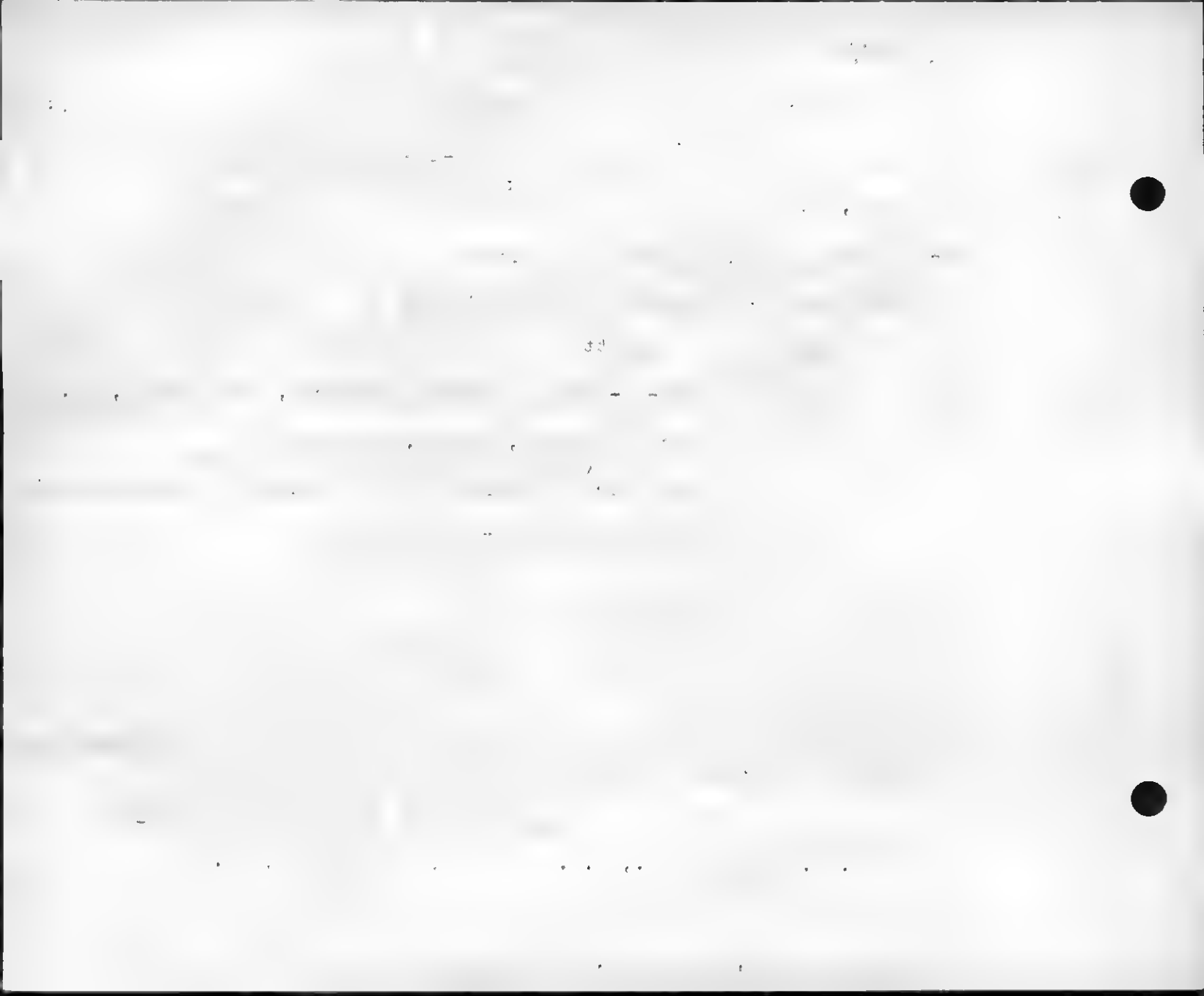


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) CHARLES B SCOTT			2a. DATE OF DEATH Month 5 Day 9 Year 68			2b. HOUR 7:00 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-15-02		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Apple Creek, Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) Maryland		13b. COUNTY Ann Arundel		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e. STREET AND NUMBER Box 391		14. FATHER'S NAME First Middle Last Charles Scott		15. MOTHER'S MAIDEN NAME First Middle Last Bessie E Lowe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 283-10-9583		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, severe, terminal DUE TO, OR AS A CONSEQUENCE OF (probable carcinoma of the brain) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic brain syndrome due to cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Epileptic seizures-probable to # 2							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 28 , 19 68 , to May 9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>T. R. Huxtable Jr.</i>						22c. DATE SIGNED 5-9-68	
22d. PHYSICIAN'S NAME (Type) T. R. HUXTABLE JR., M.D.						22e. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 5-13-68		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington Va.	
24. FUNERAL DIRECTOR <i>Taylor</i> Taylor Funeral Home, Annapolis, Maryland				25a. REC'D BY REGISTRAR DATE MAY 13 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

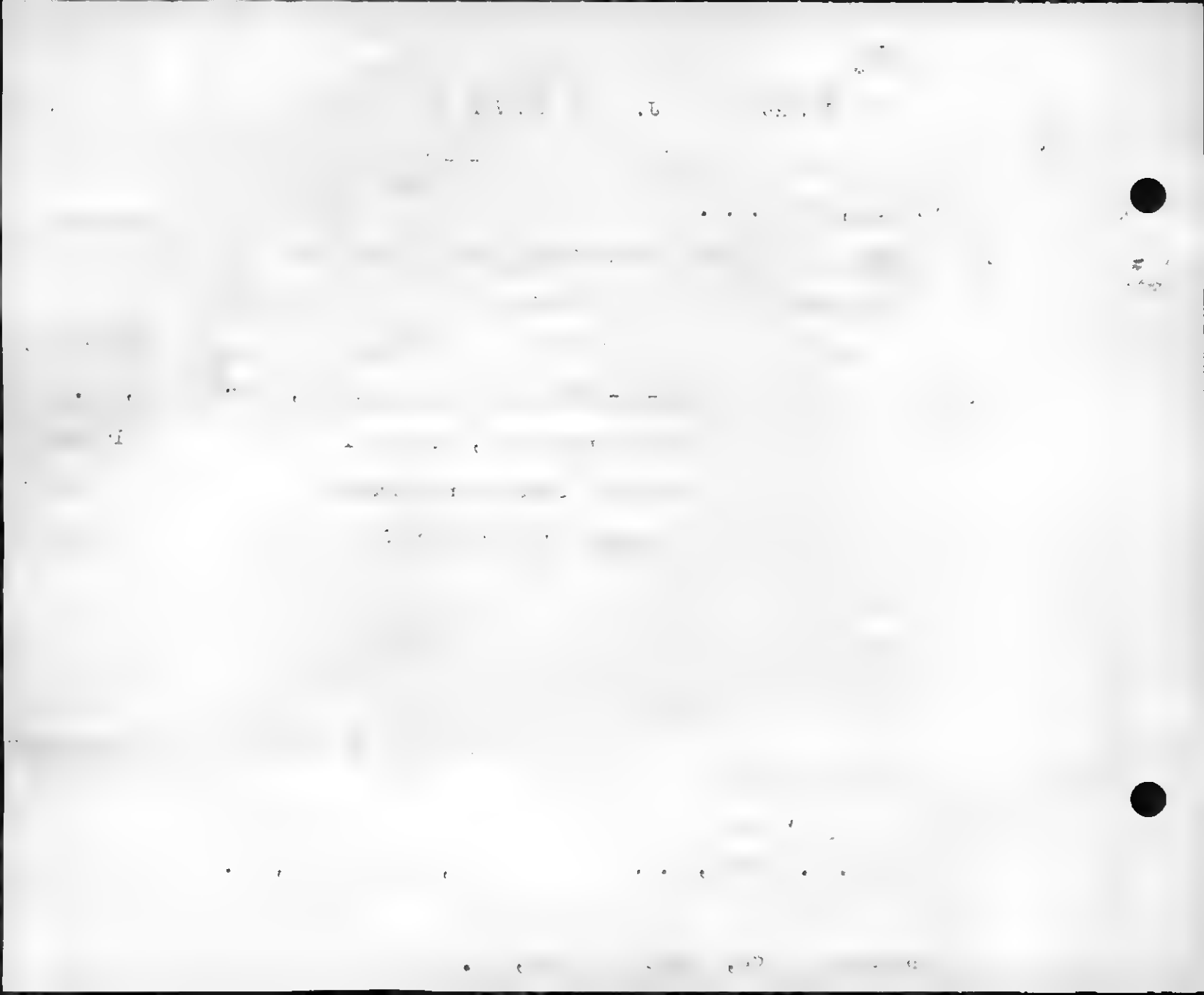


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EDWARD J. SLAVEN			2a. DATE OF DEATH Month 5 Day 29 Year 68			2b. HOUR 1:45p				
3 SEX Male		4. RACE White		5 DATE OF BIRTH 11-8-97		6 AGE (In years last birthday) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Brooklyn, NY		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Cecil Md.				
10. CITY OR TOWN OF DEATH Perry Point			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Caretaker			12b KIND OF BUSINESS OR INDUSTRY Same	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Belcamp		13c CITY OR TOWN Belcamp		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Box 213	
14. FATHER'S NAME First Middle Last John Slaven (D)			15 MOTHER'S MAIDEN NAME First Middle Last Mary Bradley (D)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16b SOCIAL SECURITY NO 153-14-1341		17 INFORMANT Address VA Hospital Records, Perry Point, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral 4337 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Infarction (Stroke) DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 6 weeks years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f LOCATION Street or RFD No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from April 13, 19 68 to May 29, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE A. L. Mooney, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>								22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.				22e ADDRESS VAH, Perry Point, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 6/4/68		23c NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem		23d LOCATION (City or Town) (County) (State) Baltimore Md				
24 FUNERAL DIRECTOR Pennington & Son, Havre de Grace, Md.		25a REC'D BY REGISTRAR DATE JUN 4 1968		25b REGISTRAR'S SIGNATURE Charles Judge						

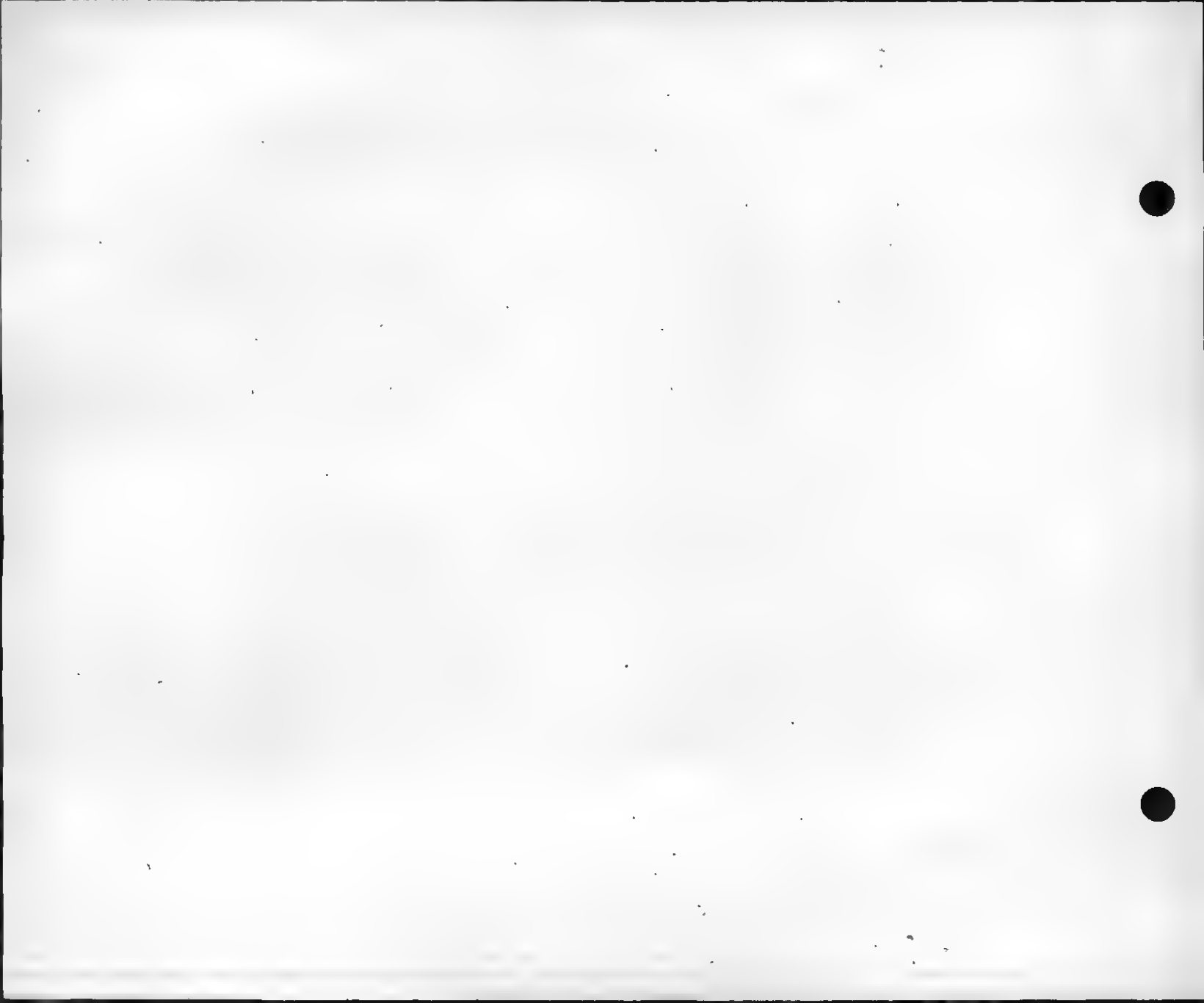


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form WM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR OF DEATH		
Harry Paul Steiner, Sr.						Month Day Year			5-9 1968 4:33 A.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
M.	W.	2-16-30	38 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year	5 9 1968 4:33 A.M.		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Pennsylvania			U.S. A.						Cecil Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Elkton			Union Hosp.			Chief			U.S. Navy		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Cecil			Port Deposit			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER			13f INSIDE CITY LIMITS?			13g STREET AND NUMBER			13h STREET AND NUMBER		
254-B Laffey Circle											
14 FATHER'S NAME (Deceased)			15 MOTHER'S MAIDEN NAME (Deceased)			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
James Paul Steiner			Mary Emma Ritty			Yes			197 24 5950		
16c ADDRESS			17 INFORMANT			18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NTC Bainbridge, Maryland 21905						PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractures of skull, multiple			Immed.		
						DUE TO, OR AS A CONSEQUENCE OF (b) due to auto accident					
						DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
227											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day, Year HOUR AM			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 8)					
			3:00 PM 5-9 1968			Thrown out of car in one-car accident					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
			Rte. 222 Hwy.			2 miles south of Port Deposit, Cecil, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b DATE SIGNED		
John M. Byers, M.D.									5-9-68		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)			Elkton, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			13 May 1968			Arlington National Cemetery			Arlington, Virginia		
24 FUNERAL DIRECTOR			ADDRESS			25a RECORD REGISTRAR			25b REGISTRAR'S SIGNATURE		
LEE A. PATTERSON & SON, PERRYVILLE, MARYLAND						MAY 17 1968			Charles Judge		



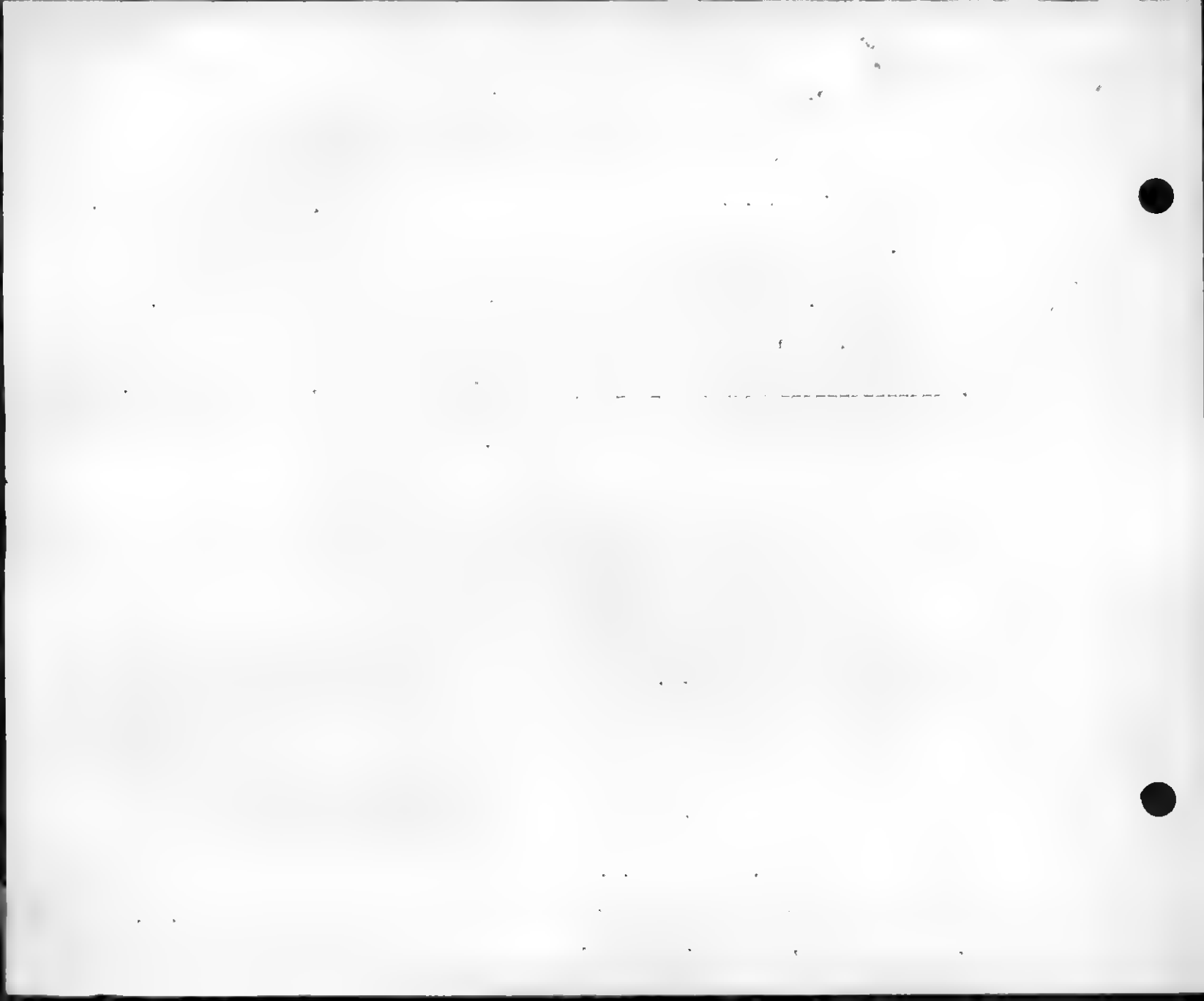
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) Gregory		First F.		Middle Stone		Last Stone		2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> DEATH MATED <input checked="" type="checkbox"/> 5 29 1968		2b. HOUR 11a M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 24, 1947		6. AGE (in years last birthday) 20 YRS.		7. UNDER YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month 6 Day 14 Year 19 68	
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil				2d. HOUR 11p M	
10. CITY OR TOWN OF DEATH Chesapeake City		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Penna.		13b. COUNTY Malvern		13c. CITY OR TOWN Malvern		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 32 Byron Ave.			
14. FATHER'S NAME First John F. Middle Stone Last Stone				15. MOTHER'S MAIDEN NAME First Ruth Middle Wellnitz Last Wellnitz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 197-36-5818		17. INFORMANT ADDRESS Mauger Funeral Home, Malvern, Penna.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF (b) 8:50 a.m. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (CAUSE OF DEATH)		21b. TIME OF INJURY Month, Day, Year May 29 1968 HOUR A.M. 10:45 A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Thrown from capsized barge							
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) river		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Edward F. Wilson				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6/15/68	
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ASSISTANT MED. EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-7-68		23c. NAME OF CEMETERY OR CREMATORY Restland Memorial Park				23d. LOCATION (City or Town) East Hanover, N. J.		(County) (State)	
24. FUNERAL DIRECTOR Wm. Cook-Brooks, 1217 St. Paul St.				ADDRESS 21202				25a. REC'D BY REGISTRAR JUN 19 1968		25b. REGISTRAR'S SIGNATURE Charles J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

06966

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06970

1. DECEASED-NAME (Type or print) HARRY			First Middle Last			2a. DATE OF DEATH Month 5 Day 15 Year 68			2b. HOUR 3:00 P.M.		
3. SEX M			4. RACE W			5. DATE OF BIRTH 8-4-1910			6. AGE (In years last birthday) 57 YRS.		
7a. BIRTHPLACE (State or foreign country) PA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH CECIL		
10. CITY OR TOWN OF DEATH ELKTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PLANT OPERATOR			12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY CECIL			13c. CITY OR TOWN ELKTON			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Middle Last HARRY			15. MOTHER'S MAIDEN NAME First Middle Last MYRTLE DEARDORF			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO			16b. SOCIAL SECURITY NO. 195-07-9929		
17. INFORMANT EVELYN V. UMBERGER			Address RD #3 ELKTON, MD.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic cardiovascular disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 5-15 , 19 68 , to 5-15 , 19 68 , that (2) (we) last saw the deceased alive on 5-15 , 19 68 , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) did (did not) view the body after death.											
22b. SIGNATURE Jay S. Barnhart, Jr.			22c. DATE SIGNED 5-17-68			22d. PHYSICIAN'S NAME (Type) JAY S. BARNHART, JR.			22e. ADDRESS 3 MAULDIN AVE. NORTH EAST, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 5-19-68			23c. NAME OF CEMETERY OR CREMATORY ELKTON CEMETERY			23d. LOCATION (City or Town) (County) (State) ELKTON CECIL MD.		
24. FUNERAL DIRECTOR RIPPIN FUNERAL HOME			ADDRESS ELKTON, MD.			25a. REC'D BY REGISTRAR MAY 20 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

2000

1525

05-25-5

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06971

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN lb Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 200 D Landing Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Thomas Middle M. Last Widdoes				4. DATE OF DEATH Month May Day 9 Year 1968			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1893		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile		10b. KIND OF BUSINESS OR INDUSTRY Baldwin Mfg.		11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Widdoes				14. MOTHER'S MAIDEN NAME Liza Jane Hamilton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-8882		17. INFORMANT Address Mrs. Jennie L. Ferguson, Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129 (b) PULMONARY EDEMA DUE TO (c) MYOTRUSCLENONIC CARDIOVASCULAR DISEASE							INTERVAL BETWEEN ONSET AND DEATH 30 min. 2 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BENIGN PROSTATIC HYPERTROPHY - PROSTATECTOMY							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 4:15 p.m. 5/9 1968		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/18 , 19 68 , to MAY 9 , 19 68 , that (I) (we) lost the deceased on MAY 9 , 19 68 , and that death occurred at 11:54 A.M. from causes and on the date stated above.							
22a. SIGNATURE Rolando A. Najera				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/13/68	
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera				22d. ADDRESS 105 E. Main St. Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/13/68		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.				25a. REC'D BY REGISTRAR MAY 15 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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